STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235187	A. BUILDING _____ B. WING _____	06/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAMBRIDGE EAST HEALTHCARE CENTER	31155 DEQUINDRE MADISON HEIGHTS, MI 48071

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 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the code status of a resident without an advance directive was determined by an authorized representative on behalf of the resident and a discussion documented in the medical record for one (R811) of three residents reviewed for Advance Directives, resulting in a physician writing and signing a Do-Not-Resuscitate (DNR) order without a discussion or consent from the resident's legal guardian and the likelihood of treatment being withheld not in accordance with the resident representative's or residents wishes. Findings include: On [DATE], a report of residents discharged from the facility between [DATE] and [DATE] was reviewed. The report documented R811 expired in the facility on [DATE]. R811's clinical record was reviewed and revealed the following: R811 was originally admitted into the facility on [DATE], was transferred to the hospital on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R811 had severely impaired cognition for decision making. R811's resident profile in the Electronic Medical Record (EMR) documented the resident's code status as Full Code (in the event that an individual's heart stops beating or they are found to have no pulse, the health care professionals will start chest compressions and/or administer an electrical shock in attempt to resuscitate their heart) and Full Code unless attending changes per guardian. Letters of Guardianship for R811 dated [DATE] indicated R811 had a full legal guardian. physician's orders [REDACTED]. Full code unless attending changes per guardian. A review of R811's progress notes revealed the following: An Admission Note dated [DATE] at 7:09 PM documented, .Resident admitted to (agency name redacted) Hospice today upon admission. Hospice nurse here to sign resident up for Hospice. Resident is a full code .Resident is non verbal and only responds by movement to tactile stimuli . A Nursing Note dated [DATE] at 10:10 PM documented, Called (agency name redacted) hospice regarding condition of resident; on call hospice nurse was contacted and returned call; could not get a reading for BP (blood pressure); pulse thread <sic> (weak) and hardly palpable; RR (respiratory rate) ,[DATE] bpm (beats per minute); T 96.0 (ax); O2 sat (oxygen saturation) 87% at 5L/M (liters per minute) NC (nasal cannula); no urine output since admitted here at around 2:30 p.m. Guardian could not be reached during off hours. A Orders-General Note dated [DATE] at 12:51 PM written by Licensed Registered Nurse (LPN) M (who was contracted to work at the facility through an staffing agency) documented, Writer was called to resident's room (room number redacted) at 12;38 pm because the CNA (Certified Nursing Assistant) stated that resident was not breathing, unit manager (name redacted) accompanied writer, upon entering room, resident was found without breathe and pulse, doctor, hospice and guardian notified. There were no progress notes that documented R811 had expired, time of death, or whether CPR was administered. The only progress note that addressed the event was documented by LPN M. At that time, the DON was queried about what happened with R811 when they were found without breathe and pulse. The DON reported they did not work in the facility at the time of the event and was not sure. On [DATE] at 12:03 PM, Social Worker O was interviewed and R811's clinical record was reviewed. When queried about who was authorized to change a resident's code status, Social Worker O reported code status could only be changed by the resident is they were their own responsible party, a legal guardian, or person designated as the resident's Durable Power of Attorney (DPOA). Social Worker O reported that when a guardian or DPOA changed a resident's code status, the physician would have a discussion with the resident's representative and until that occurred the resident would remain a full code. Social Worker O was queried about R811's code status and proceeded to review their clinical record. Social Worker O reported that based on the documentation in R811's EMR, they would have been a full code at the time of their death. Social Worker O reported R811 was unable to make their own decisions and did not have an advance directive in place and the legal guardian made all decisions for the resident. R811's clinical record was further reviewed and revealed the following: A Do-Not- Resuscitate (DNR) Order document from the hospice agency that was stamped FULL CODE and also stamped Comfort Care is Authorized DNR to be determined by the physician. It was signed by a physician on [DATE] (R811 expired a day earlier on [DATE]). The DNR order documented, Patient Name: (R811) .I have discussed my health status with my physician and I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me. The order is effective until it is revoked by me. Being of sound mind, I voluntarily execute this order, and I understand its full impact. The sections for the Declarant's signature and Signature of person who signed for Declarant, if applicable was left blank with no signature. Registered Nurse (RN) P's signature was present in the section titled, ATTESTATION OF WITNESSES .The individual who has executed this order appears to be of sound mind, and under no duress fraud, or undue influence. The witness did not include a date. On [DATE] at approximately 12:45 PM, the Administrator and Regional Nurse Consultant provided a hand written order that was scanned into the miscellaneous section of the EMR dated [DATE] at 2:20 PM that documented, DNR. The order had the same signature as the Do-Not-Resuscitate Order from the hospice agency, signed [DATE]. When queried about whether the hand written order for DNR was valid if it was not discussed with or the choice designated by R811's guardian, the Regional Nurse Consultant reported it was not and R811 would have been a full code. On [DATE] at 4:00 PM, the Administrator provided additional documents and reported the following via email regarding R811: (R811) was a DNR The DNR was confirmed by (agency name redacted) Hospice. (Hospice agency name redacted) agreement was sent from hospice to guardian. Guardian signed all pages and per interview with (RN P) Coordinator from (agency name redacted) hospice the guardian returned the documents with a stamp on the paperwork indicating Comfort Care authorized, DNR to be determined by the physician The guardian placed that stamp and FULL CODE stamp on top of the Do not Resuscitate order - requesting the physician can determine the DNR. Spoke with a representative from the guardian company (name and phone number redacted). She stated that they do not make decisions to change the DNR and it is made by the physicians or a court order based on the (state's) law. A review of the chart showed that there were 2 physicians that signed off on the order . (Physician J) who signed off on the DO NOT RESUSCITATE ORDER AND DNR order faxed to (Physician K) for signature - signed in record [DATE] . Hospice admission documents (as mentioned in the above email response) were provided by the Administrator and reviewed. The documents contained a stamped signature from R811's guardianship company, a handwritten date of [DATE], and an undated signature by RN P. The documents also included a stamp that read, Comfort Care is Authorized DNR to be determined by the physician. A hospice form used to document assigned staff to R811 documented, Medical Decision Making .Full Code. Progress notes for R811 were further reviewed and did not include any documentation from a physician, including any documentation of a discussion with R811's guardian regarding a change in code status. On [DATE] at 10:19 AM, a telephone interview was attempted with R811's guardian. A message was left. No response was received prior to the end of the survey. On [DATE] at 3:25 PM, Physician K (the physician identified by the Administrator as the physician who the DNR orders were faxed to for a signature) was interviewed via the telephone.

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 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Physician K was queried about when a physician could write a DNR order for a resident, Physician K reported they would only write a DNR order if the resident, family, or guardian requested it and after having a discussion with them. When queried about R811, Physician K reported they had not seen resident in the facility since mid-March and Physician J who was from a different physicians group was seeing Physician K's residents. When queried about signing a DNR order for R811, Physician K reported they had not seen R811 since before March and did not sign a DNR order for them. On [DATE] at 3:50 PM, LPN M was interviewed via the telephone. LPN M reported they worked in the facility periodically and they were contracted through a staffing agency. When queried about R811 and what occurred on [DATE], LPN M reported R811 was not breathing when they were assessed by themselves and RN N. When queried about whether CPR was started and stated, I didn't do anything because I went to get the supervisor (RN N). (RN N) said she was a no code. No CPR was done when I was in the room. On [DATE] at 9:10 AM, Physician J was interviewed via the telephone. Physician J reported they did see residents in the facility, but they no longer worked in the facility. When queried about when staff should perform CPR on a resident, Physician J reported it depended on the state. When queried about when a physician could write a DNR order for a resident, Physician J reported only if the guardian, family, or resident requested it. When queried about R811, Physician J reported they vaguely remembered the resident. Physician J reported they remember they were admitted into the facility from the hospital and stated, The guardianship apparently put the decision on me. Physician J reported they did not have a discussioin with R811's legal guardian, they did not physically evaluate the resident, and wrote and signed a DNR because the (former) DON of the facility called and explained the situation and they thought it was okay. On [DATE] at 10:15 AM, the facility's Medical Director was interviewed. The Medical Director reported that physician could write a DNR order after communication with a guardian, resident, or representative. A facility policy titled, Advance Directives with a revision date of February 2017 was reviewed and it documented, .Court appointed guardians or conservators generally have the authority to make health care decisions on behalf of the residents who are their wards .If a resident has not executed an advance directive and does not have capacity to do so at the time of admission, the the facility must follow state law to determine who has authority to make health care decisions on behalf of the resident . A review of the MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT, Act 193 of 1996 (Revised [DATE]), revealed that, An order executed under this section shall be on a form described in section 4. The order shall be dated and executed voluntarily and signed by each of the following persons: (a) The Declarant, the declarant's patient advocate, or another person who, at the time of the signing, is in the presence of the declarant and acting pursuant to the directions of the declarant. (b) The declarant's attending physician. (c) Two witnesses [AGE] years of age or older, at least 1 of whom is not the declarant's spouse, parent, child, grandchild, sibling, or presumptive heir. (3) The names of all signatories shall be printed or typed below the corresponding signatures. A witness shall not sign an order unless the declarant or the declarant's patient advocate appears to the witness to be of sound mind and under no duress, fraud, or undue influence. Further review of this Act revealed, Sec. 4. A do-not-resuscitate order executed under section 3 or 3a shall include, but is not limited to, the following language, and shall be in substantially the following form: DO-NOT-RESUSCITATE ORDER This do-not-resuscitate order is issued by _____, attending physician for _____. (Type or print declarant's or ward's name) Use the appropriate consent section below: A. DECLARANT CONSENT I have discussed my health status with my physician named above. I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me. This order will remain in effect until it is revoked as provided by law. Being of sound mind, I voluntarily execute this order, and I understand its full import. _____ _____ (Declarant's signature) (Date) _____ _____ (Signature of person who signed for (Date) declarant, if applicable) _____ (Type or print full name) B. PATIENT ADVOCATE CONSENT I authorize that in the event the declarant's heart and breathing should stop, no person shall attempt to resuscitate the declarant. I understand the full import of this order and assume responsibility for its execution. This order will remain in effect until it is revoked as provided by law. _____ _____ (Patient advocate's signature) (Date) _____ (Type or print patient advocate's name) C. GUARDIAN CONSENT According to MCL 700.5314 Powers and duties of guardian, amended 2018, effective [DATE], .(d) The power of execute, reaffirm, and revoke a do-not-resuscitate order on behalf of a ward. However, a guardian shall not execute a do-not-resuscitate order unless the guardian does all of the following: (i) Not more than 14 days before executing the do-not-resuscitate order, visits the ward and, if meaningful communication is possible, consults with the ward about executing the do-not-resuscitate order. (ii) Consults directly with the ward's attending physician as to the specific medical indications that warrant the do-not-resuscitate order. (e) If a guardian executes a do-not-resuscitate order under subdivision (d), not less than annually after the do-not-resuscitate order is first executed, the guardian shall do all of the following: (i) Visit the ward and, if meaningful communication is possible, consult with the ward about reaffirming the do-not-resuscitate order. (ii) Consult directly with the ward's attending physician as to specific medical indications that may warrant reaffirming the do-not-resuscitate order .
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow infection control practices according to Centers for Disease Control (CDC) guidelines and facility policy for COVID-19 (Coronavirus Disease 2019) including: the failure to don appropriate personal protective equipment (PPE) for residents on isolation precautions and perform appropriate hand hygiene, the failure to wear PPE appropriately to prevent spread of infection, the failure to change PPE between residents who tested positive for COVID-19 and those who tested negative or had an unknown status of COVID-19, and failed to clearly identify residents who were on isolation precautions, resulting in immediate jeopardy (IJ) to the safety and health of the residents due to the likelihood of COVID-19 transmission, a highly contagious and potentially [MEDICAL CONDITION]. This placed 16 residents (R#s 802, 803, 804, 805, 807, 808, 814, 815, 816, 817, 818, 819, 820, 821, 822, and 825) and all residents who resided in the facility at risk of serious harm and/or death. Findings include: The IJ was identified on [DATE]. The IJ began on [DATE]. The Administrator was notified of the IJ on [DATE] at 1:30 PM and a plan to remove the immediacy was requested. On [DATE] at 9:25 AM, an entrance conference interview with the facility's Administrator and Director of Nursing (DON) was conducted. During the interview it was explained that the 1st Floor West (1W) unit had been designated as a unit that was used for residents that were COVID19 positive or were admissions from the hospital and had an unknown status for the COVID19 virus. It was further indicated that residents with an unknown COVID19 status were presumed to be positive for [MEDICAL CONDITION] until it could be ruled out with diagnostic testing. During the interview, the Administrator and DON indicated that staff working on the 1W unit were to wear the proper PPE that included a gown, gloves, face shield and an N95 mask when entering rooms of residents who were on isolation precautions on that unit. The Administrator reported there were two residents who resided on the 1 West Unit who were positive for COVID-19. It was explained that R805 was discovered to be positive for COVID-19 despite being asymptomatic after the facility tested all residents for [MEDICAL CONDITION] on [DATE]. It was reported that R807 tested positive twice in the facility while being under observation after admission from the hospital. The Administrator reported that staff who were assigned to areas other than the 1W were required to wear masks, either N95, K95, or a surgical mask. On [DATE] at 10:00 AM, an observation of the 1 East Unit was conducted. At 10:05 AM, the Maintenance Director was observed in R819 and R820's room directly next to R820's bed. A cloth mask was observed on the Maintenance Directors face, pulled under the chin which exposed their mouth and nostrils. When queried about appropriate use of masks in the facility, the Maintenance Director stated, I was so hot. I had to take it off. Sometimes I just need a breather. The Maintenance Director reported the mask was always supposed to be positioned over the mouth and nose. R819's clinical record was reviewed and revealed R819 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. R820's clinical record was reviewed and revealed R820 was admitted into the facility on [DATE] and readmitted on [DATE]. On [DATE] at 10:10 AM, an observation of the 2 East Unit was conducted. Certified Nursing Assistant (CNA) H was observed in R821's room, speaking with the resident. A mask was observed pulled below the CNA's nose and mouth. CNA H reported she was aware the mask was supposed to be positioned over the mouth and nose and stated, It gets so hot. I can't breathe. When queried about why staff were required to wear a mask, CNA H reported there were residents who previously had fevers and died , and stated, But right now there aren't any so I don't think I will catch anything. The CNA did not acknowledge the risk of transmission of COVID-19 from staff to resident. R821's clinical record was reviewed and revealed R821 was admitted into the facility on [DATE] and most recently readmitted on [DATE] with [DIAGNOSES REDACTED]. Another staff member was observed to enter the unit carrying a yellow isolation gown. Nurse C was observed wearing an N95 mask and carrying a surgical mask. At that time, Nurse C, who was the assigned nurse on

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) the 1W Unit, was interviewed. When queried about what PPE was required prior to entering the 1W Unit, Nurse C stated, I'm not sure. I wear a mask and there are gowns and the residents are isolated because they came from the hospital. Nurse C reported all the residents were treated the same on the 1W Unit because they were all on isolation. On [DATE] from 10:30 AM to 11:40 AM, an observation of the 1W Unit was conducted. There were multiple carts containing PPE on the unit and some room doors had isolation caddy's hung on them. Some rooms had red signs with instructions to see the nurse before entering. Other rooms had signs that read, Enhanced Contact/Droplet Precautions, and some doors did not have any signage. Isolation PPE carts were not observed to be placed directly outside of any room, but rather scattered between multiple rooms. Nurse C was queried about the protocol for PPE when caring for residents on the 1W Unit, Nurse C reported staff reused gowns for all residents on the unit. Nurse C was asked if there were any residents on the 1W Unit that tested positive for COVID-19 and indicated R805 tested positive and was moved onto the unit the day prior. Nurse C was unsure if any other residents were positive for COVID-19 and did not attempt to clarify if there were any others. Nurse C reported they knew about R805 because it was reported verbally by the midnight shift. When queried about the different signage and isolation carts observed on and outside of residents rooms and doors, Nurse C reported the signage did not indicate anything different for any room on the unit and all residents were on the same isolation precautions. At approximately 10:35 AM, Occupational Therapist (OT) D and PTA E were observed in the doorway of R814's room. OT D and PTA E removed their gloves and placed them in the trash can inside of the resident's room and exited the room without performing hand hygiene. There was no alcohol-based hand rub (ABHR) observed in the hallway. OT D and PTA E proceeded to walk down the hallway, open a PPE cart located further down the hallway, remove shoe covers, apply shoe covers while holding on to the handrail in the hallway. OT D and PTA E then entered R825's room. OT D and PTA E exited R825's room at approximately 11:20 AM, no longer wearing yellow isolation gowns. At that time, OT D and PTA E were interviewed regarding the PPE and hand hygiene protocol for the 1W Unit. OT D reported they wore a gown, mask, and gloves; discarded gloves before leaving a resident's room and discarded the gown before leaving the last resident's room prior to exiting the unit. When queried about when hand hygiene should be performed, OT D reported they removed their gloves before exiting a resident's room and then washed them with soap and water upon entrance of the next resident's room. OT D and PTA E were not sure if there were any residents on the 1W Unit that were positive for COVID -19. R814's clinical record was reviewed and revealed R814 was most recently readmitted into the facility from the hospital on [DATE]. R825's clinical record was reviewed and revealed R825 was most recently readmitted on [DATE] and had [DIAGNOSES REDACTED]. R825's room was located within the double doors on the 1W unit. However, it was unclear why R825 was assigned to a room on the COVID-19 positive/COVID-19 unknown unit. At approximately 10:40 AM,
CNA A and CNA B were observed to be performing CNA tasks on the unit. CNA 'B' was observed to be wearing a black homemade cloth face mask. They were not observed to have an N95 mask on under their cloth mask. When CNA 'B' was observed, only one set of black ties around their head to hold the cloth mask in place was observed. At approximately 10:55 AM, CNA A and CNA B were interviewed. When queried about how they were informed of residents who were positive for COVID-19, CNA A and CNA B reported they were not informed by anyone in the facility and did not know. When queried about the PPE protocol for the 1W Unit, CNA B reported they were instructed to use the same gown for all residents on the 1W hallway unless they became soiled. At approximately 11:05 AM, CNA 'B' was observed from the hallway in R816's room. When they finished assisting R816, they removed their gown and gloves and exited the room. CNA 'B' was not observed to perform hand hygiene prior to exiting the room. Upon exiting the room, R816 requested CNA 'B' return and cover her with a blanket. CNA 'B' then re-entered the room without donning an isolation gown or gloves and assisted R816. CNA 'B' then exited the room. Clean gowns and gloves were observed outside of the resident's room. R816's clinical record was reviewed and revealed the were readmitted to the facility from the hospital on [DATE] with [DIAGNOSES REDACTED]. At approximately 11:10 AM, CNA 'A' and CNA 'B' were
observed passing water to residents on the 1W unit. CNA 'B' entered R818's room to retrieve the empty cup of water, they were not observed to don an isolation gown or gloves prior to entering. CNA 'B' then exited the room and stood in the hall by the doorway. CNA 'A' then entered R818's room with a full cup of water and was not observed to don an isolation gown or gloves. Gowns and gloves were observed to be available outside of the resident's room. CNA 'A' then exited the room and moved the ice cooler down the hall. CNA 'A' was not observed to perform hand hygiene prior to exiting the room, immediately upon exiting, or before having contact with the ice cooler. After CNA 'A' moved the cooler, CNA 'B' again re-entered R818's room without donning an isolation gown or gloves. CNA 'B' attended to R818 and exited the room without performing hand hygiene. CNA 'B' was overheard to say, I have to go wash my hands and was observed to exit the 1W unit through the closed double doors and walk towards the nursing station on the first floor. R818's clinical record was reviewed and revealed R818 was readmitted into the facility on [DATE], discharged to the hospital on that same day, and readmitted into the facility on [DATE] with [DIAGNOSES REDACTED]. R818 had an unknown status of COVID-19 due to refusal of COVID-19 testing after admission into the facility from the hospital. At approximately 11:01 AM, PTA F was observed from the doorway of R822's room. PTA F removed their gloves and discarded them in the trash can in R822's room. PTA F exited R822's room without doffing the yellow isolation gown and without performing hand hygiene. PTA F walked to the other end of the hallway and entered R817's room. At approximately 11:40 AM, PTA F was observed from the hallway removing their gloves and gown and exited R817's room without performing hand hygiene. At that time, PTA F was queried about when they performed hand hygiene between exiting R822's room and entering R817's room. PTA F reported their washed they hands in R817's room because there was no hand sanitizer in the hallway. When queried about any hand hygiene performed prior to exiting R817's room, PTA F reported they had not yet washed their hands and would do it after leaving the 1W Unit. PTA F then exited the double doors of the 1W Unit and walked toward the nurses' station. R817's clinical record was reviewed and revealed a re-admission date of [DATE] with an unknown COVID-19 status. A review of R805 and R807's (the two residents identified as testing positive for COVID-19 who resided on the 1 W Unit) clinical records was conducted and revealed the following: R805's clinical record was reviewed and revealed R805 admitted from the hospital on [DATE]. R805 was tested for COVID-19 on [DATE] and on [DATE] it was reported to the facility that they were positive for [MEDICAL CONDITION]. R807's clinical record was reviewed and revealed R807 was admitted into the facility from the hospital on [DATE] with a [DIAGNOSES REDACTED]. On [DATE] COVID-19 testing was ordered by the physician. Progress notes documented R807 was diagnosed with [REDACTED]. A facility progress note documented R807 tested positive while in the facility on [DATE]. On [DATE] at 12:12 PM, the Administrator and DON were interviewed. When asked for clarification about isolation precautions on the 1 West Unit, it was reported that all the residents on that unit were treated as if they were positive. It was reported that a N95 mask, gown, gloves, and goggles or face shield were to be worn for, All residents on isolation and hand hygiene would be performed prior to exiting the resident's room. When queried about the different signage on the resident's doors and the location of the PPE isolation carts, the Administrator reported the signs did not indicate anything different and the rooms that had isolation carts outside of them meant the resident was on isolation. It was reported staff were informed by the unit managers about who was on isolation precautions and it was discussed in morning meeting. The Administrator and DON did not offer a response as to why no staff that was working on the 1W Unit knew the residents' isolation status. The Administrator and DON further reported there were three residents on the unit that were not currently COVID19 positive and were not in isolation on that unit (R's 803, 804 and R808). It was noted this information conflicted with what was reported in the earlier interview upon entrance to the facility when the Administrator and DON reported all residents on the unit were on isolation precautions.
They were then queried about why R803, R804, and R808 resided on the 1W (COVID19/Observation) unit when they had not recently been out to the hospital and had been tested and were COVID19 negative. They explained that R803 and R804 were not being treated as 'positive' or 'COVID19 status unknown'. They further explained that R803 and R808 refused to move. At that time, they were asked to provide documentation of R803's and R808's refusal to move or evidence that they had been educated on the risks of staying on the 1W unit. No documentation was provided by the end of the survey. On [DATE] at approximately 12:30 PM, a second observation of the 1W unit was conducted. During the observation, Housekeeping Staff 'G' was observed to enter the unit. Staff 'G' proceeded to go to the dining room at the end of the hall. While in the dining room an interview with Staff 'G' was conducted. Staff 'G' was observed to pull their surgical facemask down below their nose and mouth to participate in the interview. At the conclusion of the interview, Staff 'G' placed the mask back over their nose and mouth, retrieved the trash from the dining room and exited the unit through the closed double doors with the trash bag. Staff 'G' was not observed to perform hand hygiene after touching their mask, or prior to exiting the unit.
During the second observation of the 1W unit, R803 and R804 were observed together in a shared room and R808 was in a private room at the end of the hallway. A review of R803's clinical record was conducted and revealed an original admission date of [DATE] and a most recent readmission date of [DATE]. A review of R803's census information was conducted and revealed that R803 had resided on the same unit (1W) in the same room since 2018. A review of R804's clinical record was

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) conducted and revealed an admission date of [DATE] and a most recent readmission date of [DATE]. A review of R804's census information was conducted and revealed R804 had been moved from the second floor to the 1W unit on [DATE]. A review of R808's clinical record was conducted and revealed an admission date of [DATE] and a most recent readmission date of [DATE]. A review of R808's census information was conducted and revealed R808 had resided on the same unit (1W) and in the same room since [DATE]. There were no progress notes or documentation prior to [DATE] that indicated R803, R804, and R808 were informed about COVID-19 positive residents and the risks of staying on the 1W Unit. On [DATE] at approximately 12:00 PM, a second interview regarding R804 being transferred from the second floor to the 1W unit on [DATE] was conducted. The DON indicated they did not know why R804 had been moved to that unit considering they had not been out to the hospital (requiring isolation and observation). R802 On [DATE] at approximately 10:05 AM, an observation of the 1st Floor Central unit was conducted. During the observation, R802 was observed in their room in bed. It was not observed that there was any signage on the door indicating any type of isolation precautions, nor was an isolation supply cart observed outside of the room. On [DATE] at approximately 1:00 PM, a second observation of the 1st Floor Central unit was conducted. At that time, it was observed R#802 had a sign posted on their room door that indicated they were on droplet isolation precautions. An isolation supply cart was not located at, or near the vicinity of R802's room. On [DATE] at 1:05 PM, Nurse C was interviewed. When queried about why R802 had signage on their door that indicated they were on droplet isolation precautions, Nurse C reported they did not know, and they thought they came from the hospital. Nurse C did not review the medical record to clarify. On [DATE] at 2:50 PM, a review of R802's clinical record was conducted and revealed they originally admitted to the facility on [DATE]. On [DATE], R802 had been found unresponsive and had been sent to the emergency room where they were treated and re-admitted to the facility on [DATE] to a room on the 1st floor Central Unit, not to a room on the 1W unit; the unit the Administrator and DON had previously reported that all hospital admissions were placed on. On [DATE] at 11:10 AM, an interview with the DON was conducted regarding R802's isolation status and placement on the 1st Floor Central unit (after hospitalization) was conducted. The DON indicated the orders for isolation needed to be discontinued and that a mistake had been made and R802 should have been placed on the 1W unit for 14 days of observation. A review of policies and procedures provided by the facility was conducted. A facility policy titled, Hand Hygiene documented, .Handwashing/hand hygiene is generally considered the most important single procedure for preventing healthcare associated infections .When hands are visibly dirty or contaminated with proteinaceous material, are visibly soiled with blood or other body fluids, after going to the restroom, before eating, before performing an invasive procedure, and after providing care to a resident with a spore-forming organism (e.g. [DIAGNOSES REDACTED]icile), perform hand hygiene with either a non-antimicrobial soap and water or an antimicrobial soap and water .If hands are not visibly soiled, use an alcohol-based hand rub . A facility policy titled, Glove Use documented, .Used gloves should be discarded into the nearest waste receptable inside the room .Perform hand hygiene after removing gloves . A facility document titled, Tool Kit A - Section II Center Preparedness: Infection Prevention Strategies and Guidance for COVID-19 Update - [DATE] which was explained by the Administrator to include all policies and procedures regarding the facility's infection control protocols for COVID-19 included a decision making tree on page 83. The decision tree documented if staff were working on an Admission/Observation Unit or a COVID-19 positive unit they were to wear Full PPE (N95, Gown, Eye Protection, Gloves). The immediacy was removed [DATE] based on the facility's implementation of an acceptable plan of removal as verified by the survey team. Although the IJ was removed on [DATE], the facility remained out of compliance at a scope of widespread and a severity of potential for more than minimal harm that is not Immediate Jeopardy due to sustained compliance not yet having been verified by the State Agency. The facility submitted the following plan to remove the immediacy: On [DATE] the (agency name redacted) entered the facility to conduct an abbreviated survey along with infection control COVID survey. Based on the feedback from the surveyors upon their exit, an ADHOC QAPI was held with Department Heads and education regarding hand hygiene and PPE usage was initiated. Administrator and Director of Nursing completed grand rounds to ensure appropriate PPE was worn and easily accessible. On [DATE] and <sic> Immediate Jeopardy was called based on the following allegations: The facility did not don proper PPE for residents on isolation precautions and perform hand hygiene (CNA's, therapy, housekeeping). The facility did not wear PPE appropriately to prevent spread of infection (maintenance staff and CNA) The facility did not change PPE between residents with unknown COVID-19 and negative status and residents with confirmed positive COVID-19 status. Resident who were on isolation precautions were not clearly identified. The residents identified were 802, 803, 804, 805, 807, 808, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, and 825 with the potential to affect all residents in the facility. Element 1: Resident #802, 803, 804, 805, 807, 808, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825 at time of admission were placed into isolation on the admission observation unit. Residents residing on this unit are monitored closely using droplet precautions outlined in our toolkits. Residents are then tested on day 12. National Guard did full house testing on [DATE]. Resident 802 was tested on [DATE] and results received on [DATE] were negative. Resident 803 was tested on [DATE] and results received on [DATE] were negative. Resident 804 was tested on [DATE] and results received on [DATE] were negative. Resident 807 was tested on [DATE] and results received on [DATE] were negative. Resident 808 was tested on [DATE] and results received on [DATE] were negative. Resident 814 was tested on [DATE] and results received on [DATE] were negative. Resident 815 was tested on [DATE] and results received on [DATE] were negative. Resident 816 was tested on [DATE] and results received on [DATE] were negative. Resident 817 was tested on [DATE] and results received on [DATE] were negative. Resident 819 was tested on [DATE] and results received on [DATE] were negative. Resident 820 was tested on [DATE] and results received on [DATE] were negative. Resident 821 was tested on [DATE] and results received on [DATE] were negative. Resident 822 was tested on [DATE] and results received on [DATE] were negative. Resident 823 was tested on [DATE] and results received on [DATE] were negative. Resident 824 was tested on [DATE] and results received on [DATE] were negative. Resident 825 was tested on [DATE] and results received on [DATE] were negative. Resident # 818 will be tested on [DATE] by the facility. Resident # 805 was tested on [DATE] and results received on [DATE] were positive. She was immediately moved into isolation and put on droplet precautions. Resident #806 was tested on [DATE] and results received on [DATE] were positive. Resident was immediately placed in isolation on droplet precautions. Both residents were transferred to (facility name redacted) on [DATE] @ 6pm. Therapist 1 (initials redacted) has received a 1:1 education on hand hygiene and PPE usage Therapist 2 (initials redacted) has received a 1:1 education on hand hygiene and PPE usage Therapist 3(initials redacted) has received a 1:1 education on hand hygiene and PPE usage CNA (initials redacted) has received a 1:1 education on hand hygiene and PPE usage CNA (initials redacted) has received a 1:1 education on hand hygiene and PPE usage Housekeeper (initials redacted) has received a 1:1 education on hand hygiene and PPE usage Maintenance (initials redacted) has received a 1:1 education on hand hygiene and PPE usage Element 2: Residents in the facility have the potential to be affected in a similar manner. On the admission/observation unit the same PPE, except gloves can be worn between residents unless transmission based precautions are necessary for another diagnosis. On the well/non COVID unit standard precautions and a surgical mask are worn when providing care. Center will continue to use enhanced droplet precautions for COVID positive patients in house. Element 3: All staff have been re-educated on the hand hygiene guidelines and COVID free PPE decision tree. New hires will be educated on hand hygiene guidelines and PPE usage during orientation. Element 4: Department Heads during daily rounds will conduct random hand washing audits and will provide immediate 1:1 education as indicated. Department Heads will report all findings to the Administrator during morning stand up meeting Mon-Friday. Director of Nursing/designee will conduct PPE monitoring ,[DATE] times a week to ensure proper usage and availability. Director of Nursing/designee will report findings to the QAPI committee weekly until further directed. Element 5: Administrator is responsible for compliance. Date of compliance: [DATE]