STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366008	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRANDE POINTE HEALTHCARE COMMU	THREE MERIT DR RICHMOND HEIGHTS, OH 44143

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to inform Resident #143's guardian and power of attorney (POA) when the resident was placed on supplemental oxygen after previously not needing it. This affected one (Resident #143) of three residents reviewed for changes in condition. The total census was 139. Findings include: Interview with the guardian of Resident #143 (a former resident) on 09/14/20 at 12:49 P.M. revealed she was not informed when or why the facility placed Resident #143 on supplemental oxygen. She expressed frustration with getting information, saying the facility did not call with updates, and she could not get anyone to pick up the phone when she called. Record review of Resident #143 revealed admission on 05/21/18 and sent to the emergency roiagnom on [DATE] due to oxygen desaturation while on 10 liters of oxygen. The resident had not returned to the facility. A progress note dated 05/20/20 revealed the resident's pulse oximetry was 98% on room air (the common ideal pulse oximetry values are 92%-100%). Review of her oxygen vital signs assessments revealed she was placed on supplemental oxygen via nasal cannula on 05/22/20, and then was on it from 05/24/20 to 05/27/20. Review of the progress notes and assessments from 05/22/20 onwards revealed no mention of why the resident was initially placed on oxygen or that the guardian was informed of her being on oxygen any time before the hospitalization on [DATE]. Review of the resident's orders revealed an order for [REDACTED].M. Review of the Notification of Change in Condition policy dated 05/30/19 revealed that when a change in condition was noted, the nursing staff was to contact the resident representative. The nurse was to record in the progress notes the name of the person called and the time they were contacted. This deficiency substantiates Complaint Number OH 210, Complaint Number OH 279, Complaint Number OH 389 and Complaint Number OH 575.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation, record review and interview, the facility failed to ensure staff followed appropriate precautions for residents ordered to be on isolation in their At Risk (for COVID exposure) skilled care unit. This affected two (Resident #69 and Resident #27) of sixteen residents in the facility on isolation precautions. The total census was 139. Findings include: 1. Observation on 09/08/20 at 10:33 A.M. revealed Resident #69's room had a sign by the door indicating the resident was on droplet precautions. The sign instructed staff to perform hand hygiene and wear a mask before entry, and to use a gown, gloves, and eye protection if contact with secretions was expected. Housekeeper #201 was in the room cleaning while wearing a mask, eye shield, and gloves, with no gown. The resident was not in the room. Interview with Housekeeper #201 on 09/08/20 at 10:35 A.M. confirmed the above observations. She said she did not need to wear a gown in isolation rooms when providing housekeeping. Interview with the Infection Control Director, Licensed Practical Nurse (LPN) #301, on 09/08/20 at 10:40 A.M. revealed the facility placed all new admissions on droplet precautions for 14 days, as well as residents who had routine appointments outside of the facility. These precautions were put in place to help contain and prevent possible COVID exposure. The facility had no residents in isolation for a different reason (such as confirmed COVID or other infectious disease) at this time. Everyone who entered droplet isolation rooms were to wear a mask, face protection, gloves, and gown, including those not providing direct care. The surveyor reviewed the above observation with LPN #301 at this time. Record review of Resident #69 revealed she had an order dated 08/17/20 for strict isolation with droplet precautions. 2. Observation on 09/08/20 at 3:04 P.M. revealed Physical Therapy (PT) Worker #204 in Resident #27's room wearing a mask with no gown or gloves. There was a droplet isolation sign and personal protective equipment (PPE) container outside the room. The surveyor observed PT Worker #204 handling what appeared to be the resident's oxygen concentrator and walker. The resident was sitting upright in a chair in the room at this time. Interview with PT Worker #204 on 09/08/20 at 3:29 P.M. confirmed he did not wear gloves or gown in the room, and confirmed he should have. When the surveyor asked if he had washed or sanitized his hands before exiting the room, he said he did not and was going to the gym to perform hand hygiene. Record review of Resident #27 revealed he had an order dated 08/19/20 for strict isolation with droplet precautions. Review of a map furnished by the facility revealed the At Risk section of the facility included the Resident's #69 and #27's rooms. Review of the facility Criteria for COVID-19 Isolation policy dated 08/04/20 revealed the At Risk unit was to be used for residents who may be at risk for COVID-19, such as new admissions. Full personal protective equipment (PPE) was to be worn while working on the unit, including N95 masks, gloves, gown, and eye covers. Hands were to be washed or sanitized prior to entering a resident room and upon exiting the room. This deficiency substantiates Complaint Number OH 352.

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.