STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235641	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHESANING NURSING AND REHABILITATION CENTER	201 S FRONT ST CHESANING, MI 48616

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 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number MI 618. Based on interview and record review, the facility failed to ensure assessment, monitoring and notification to the physician in a timely manner for a resident experiencing a change in condition for one sampled resident (Resident #101) of three residents reviewed for care needs, resulting in Resident #101 exhibiting a change in mental status, a fever, and experiencing confusion. The facility failed to perform continued assessment, monitoring and the evaluation of STAT (immediate) laboratory findings, There was a deterioration in the resident's health status with subsequent death. Findings include: A review, of Resident #101's medical record, revealed an admission into the facility on [DATE] from the hospital with [DIAGNOSES REDACTED]. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status of 15, which indicated intact cognition and the Resident needed extensive staff assistance with transfers, dressing, personal hygiene and toilet use. A review, of Resident #101's medical record, revealed progress notes that included the following: -Dated [DATE] at 11:02 AM, Admission Note, . Resident was diagnosed at hospital with [MEDICAL CONDITION] and tested positive for a UTI (urinary tract infection), treated with PO (oral) abx (antibiotics) . Resident is continent of bowels and bladder, uses urinal and bedpan for elimination . Resident is A&O x 4 (alert and oriented), education provided on use of call light system and bed controls . -Dated [DATE] at 8:34 AM, Nurses Progress Notes, Resident has had increased confusion noted during the night. Has had to be redirected numerous times. He is on oral ABT (antibiotic) therapy for UTI. Per resident days ago when he was more lucid, he was on IV (intravenous) ABT therapy at the hospital, but was changed over to a oral pill. I discussed with the oncoming nurse my concerns about his decline in cognition. Put into the doctor's book, author Nurse K. -Dated [DATE] at 1:37 PM, Nurses Progress Notes, Resident has had increased confusion. Vitals taken this morning included a temp of 100.1. Retake temp at noon was 99.1 tympanic. He continued to have periods of confusion. Skin warm and dry. Alert but has had some times where he was difficult to arouse but when he did he would talk with confused content then would be more with it then confusion again. Meds given. Abdomen has redness. Held [MEDICATION NAME] this afternoon. Spoke with (Doctor E) and received orders for [MEDICATION NAME] 1 gram IM (intramuscularly) daily for 5 days. Stat labs for a CBC (blood count), Chem 7 (basic metabolic panel that included electrolytes and kidney function), U/A (urinalysis), HGB A1C (glucose indicator), PT/INR (coagulation). He is awaiting the DON (Director of Nursing) for Face Time with an iPhone. He gave order for Tylenol 325 2 tabs every 6 hours as needed for fever, author Nurse O. -Date [DATE] at 2:29 PM, Nurses Progress Notes, Resident incontinent of bladder and bowel. Urine had somewhat yeasty odor. [MEDICATION NAME] 1 GM IM and oral Tylenol 650 given per new DO (doctor's order), author Nurse O. -Dated [DATE] at 3:50 PM, Nurses Progress Notes, urine dip was negative. Brat diet started, author DON. -Dated [DATE] at 8:30 PM, Nurses Progress Notes, 2030 (8:30 PM) nurse entered Pt (patients) room and called a code BLUE, Pt was unresponsive, 911 called and CPR (cardiopulmonary resuscitation) started with EAD (AED, Automated External Defrillator) activated. 2043 (8:43 PM) EMT (emergency medical technician) arrives on scene, CPR continues. 2127 (9:21 PM) time of death and ME (medical examiner) called, 2300 (11:00 PM) (Funeral Home) called, remains left building at 23:45 (11:45 PM), Family and D.O.N. notified. Personnel belongings sent with family, author Nurse J. A review, of Resident #101's vital signs in the medical record, revealed one set of vitals on [DATE] at 8:41 AM that included blood pressure of ,[DATE], and oxygen saturation of 95% that was recorded by the nightshift Nurse K. The temperature was recorded in the nurse's progress note that was completed in the morning on [DATE] of 100.1 degrees Fahrenheit and retaken at noon of 99.1 degrees Fahrenheit. There was a lack of vital signs of pulse, blood pressure, oxygen saturation and respirations documented on [DATE] with the ongoing confusion for Resident #101 and a lack of further assessment and monitoring of the Residents condition after Nurse O had notified the Physician of the change in condition at 1:37 PM on [DATE] until the Resident had been found unresponsive at 8:30 PM when CPR had been initiated and the Resident had died . A review, of Resident #101's medical record, revealed laboratory orders dated on [DATE] at 2:00 PM for STAT CBC, BMP (basic metabolic panel), US C&S (urine culture and sensitivity), PT/INR, and Hgb A1C. The laboratory results revealed a collection on [DATE] at 4:41 pm, received on [DATE] at 5:54 PM and a run date on [DATE] at 4:02 AM. Abnormal results included CL (chloride level) low at 93 (normal range ,[DATE]), Gap (anion gap) high 21.4 (normal range ,[DATE]), BUN (blood urea nitrogen) high 68 (normal range ,[DATE]), Creat (creatinine level) high 2.2 (normal range 0XXX,[DATE].3), Est Creat Clear low 32 (normal range greater than 60). An interview on [DATE] at 8:01 AM, with Laboratory Staff P was conducted and revealed that a composite of all the lab results for Resident #101 had been faxed on [DATE] at 4:02 AM. The Laboratory Staff was queried regarding the time frame for STAT orders for test to be completed and reported that the lab has four hours from initiate to collect, receive and run the test results and stated, That's our target window for STATs. A review, of the lab test from Resident #101's medical record, of the run time on [DATE] at 4:02 AM, the Lab Staff indicated the results were sent to the facility and received the scheduled report at that time with all the results. The Lab Staff reviewed communication with the facility and stated that a broadcast had been sent after the tests were run for the individual results and that the broadcast had been sent by fax as the results came in on the completed tests. The Lab Staff reported the glucose was sent at 18:14 (6:14 PM), coagulation test at 18:09 (6:09 PM), and CBC at 17:38 (5:38 PM) and another at 17:41 (5:41 PM). The Lab Staff indicated that had there been any critical results, the Lab Staff would call the facility with the results. On [DATE] at 8:23 AM, an interview was conducted with the Director of Nursing (DON) regarding Resident #101. The DON reported the Resident had increased confusion and agitation the day before the Resident had coded and died . The DON reported the Resident had progressively gotten worse, was found unresponsive and CPR was started, the responsible party was there at the facility and told staff to stop the CPR. The DON was queried if an investigation had been completed and the DON indicated the Doctor had done a chart review. When queried when the stat laboratory results had been received, the DON indicated the lab results had gotten back to the facility the next day and stated, I know for a fact the labs came after he passed, and reported they had reviewed them in the morning on [DATE]. The DON indicated if there were any critical results the Laboratory would call. When queried if the results had come by fax one at a time as the lab had preformed the test, the DON stated, I don't know if they can separate the results. Usually we get them all sent at once. When queried when STAT lab results were to be reported, the DON reported approximately four hours. The DON was queried when a change in condition in Resident status was to be conveyed to the Physician and stated, Any change in condition, they (Nurses) should be notifying (the doctor). When queried why the nightshift Nurse had not contacted the Physician with the change in the mental status and then when the temperature had elevated, the DON stated, I can't speak to why she didn't call the Doctor. The DON reported the nightshift will pass it on in report unless it is critical. The change of condition was passed on to Nurse O in the morning and Nurse O had notified the Physician and stated, that's when he ordered the labs. The DON was queried when Nurse O had notified her of the change in Resident #101's condition and stated,

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 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) (Nurse O) told me about him at the time she called the doctor. When queried when vital signs were to be done, the DON reported with a change in condition, once a day with skilled charting and reported that temperatures and O2 saturation was completed twice a day during the Covid-19 and stated, That's how (Nurse O) knew he had a fever, temps are done twice a day. When queried regarding a lack of ongoing vital signs, assessment of the Resident's condition and when should vital signs be completed for a Resident with a change in condition, the DON stated, I don't know why there is no vital signs documented. I would have the CNA's (certified nursing assistants) get a set of vital signs because I would want to know what is going on. Nurse O noticed a change in condition got the (elevated) temp and called the doctor. When queried why the Resident was not sent out to the hospital, the DON reported that the confusion was not abnormal for the resident and with the co-morbidities, UTI and because of Covid-19, the doctor thought we should try things in-house first. On [DATE] at 8:58 AM, an interview was conducted with Nurse O who was assigned care of Resident #101 on [DATE]. The Nurse explained she had been asked to work the floor (be assigned resident care) and it had been her third time working the floor after five years. When queried regarding Resident #101, the Nurse explained she had gotten report from the nightshift nurse that the Resident had a change in condition, was confused and ran a temperature of 100.1. When queried why Nurse K had not called the doctor with the Resident's change in condition that was documented as occurring through the nightshift or why she had not called the doctor after report, Nurse O reported Nurse K had a difficult night and was distraught over multiple issues through the night and after report Nurse O reported that she felt she was two hours behind on what needed to be done. The Nurse explained that another day shift nurse was assisting with medication pass and had passed the medications to Resident #101. Nurse K reported she had talked to the DON when she got there in the morning regarding Resident #101 and asked the DON if she should send him out to the hospital and stated, She (DON) said 'I will call the doctor' and I was running like crazy. I asked multiple times if (DON's name) had heard from the doctor but they said she was out to lunch, so I called him (Doctor E) myself and he had not heard from her (the DON). The Nurse reported the doctor did not want to send him out to the hospital and wanted to treat him there at the facility and had ordered lab work, an antibiotic and Tylenol. The Nurse was queried regarding an assessment and vitals and reported staff had been in and out almost every 10 minutes, a set of vitals were taken in the morning and taken again but was unsure why the vital signs had not been documented. The Nurse reported she was done with her shift at 2:30 PM and had given report to the DON on the Residents she was assigned that included Resident #101. On [DATE] at 10:57 AM, a phone call was made to Nurse K but there was no answer and a return phone call was not received prior to the exit of the survey. On [DATE] at 11:04 AM, an interview was conducted with CNA M regarding Resident #101. The CNA reported she had assigned care of the resident on [DATE] and had given him his dinner tray. The CNA explained the Resident was sweating profoundly, had talked to the CNA and said he was not hungry, and she had left the tray in-case he wanted to eat. The CNA further explained that Nurse J had gone in to pass his medication and had called for the crash cart and stated, He (Resident #101) was foaming at the mouth and was purple. He (Nurse J) was unable to find a pulse and he started CPR (Cardiopulmonary Resuscitation) right away. The CNA reported 911 was called and EMS arrived pretty quick and had taken over CPR. The CNA explained the Resident had not eaten any of his dinner. On [DATE] at 11:44 AM, an interview was conducted with Physician E regarding Resident #101. The Doctor was queried regarding when the Doctor was to be notified of a change in condition and reviewed Resident #101 with a change in mental status during the nightshift and a fever and continued confusion on [DATE], the Physician stated, Usually notify right away, text, call right away. When queried when the Physician was available to be notified, the Physician reported he and the Physician's Assistant were available twenty-four, seven. The Physician reported that laboratory tests were ordered right away after notified of the Resident's change in condition. The Physician was queried why the Resident was not sent to the hospital. The Physician indicated the Resident's vital signs were stable, had no signs or symptoms [MEDICAL CONDITION] and with the Covid situation, we try to treat him at the facility. A review of the laboratory results from [DATE] and [DATE] the Physician reported the labs were not to different. On [DATE] at 2:48 PM, an interview was conducted with Nurse J who had assigned care of Resident #101 on [DATE]. The Nurse reported he had said Hi! to the Resident when he had come into work and when he had gone back in at 8:30 PM, to give the Resident his medications, found the Resident unresponsive and started CPR. The Nurse was unable to remember the Nurse he had received report from or the content of the report. On [DATE] at 11:09 AM, an interview was conducted with Nurse I regarding facility policy on notifying a physician or provider with a change in Resident's condition with a change in mental status and elevated temperature. The Nurse reported that changes in a Resident's status would be conveyed to the Physician immediately and stated, It doesn't matter at what time day or night. A review of the facility policy entitled, Notification of Changes, reviewed/revised on ,[DATE], revealed, . compliance Guidelines: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status . 3. Circumstances that require a need to alter treatment. This may include: a. New treatment. b. Discontinuation of current treatment due to: i. Adverse consequences. ii. Acute condition. iii. Exacerbation of a chronic condition .