STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING _____ B. WING _____	04/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and observation, the facility failed to follow CDC guidance during a pandemic and implement an infection control program for timely and accurate assessment of signs and symptoms of COVID-19, continued monitoring of symptoms and ensuring proper isolation requirements and testing were initiated timely to prevent [MEDICAL CONDITION] from spreading, for 15 of 15 residents reviewed for infection control (Residents H, J, D, E, B, C, F, K, L, M, N, Q, S, G, P). As of [DATE], the facility had 39 confirmed COVID-19 cases, including 2 deaths and 2 currently in the hospital. On [DATE], two residents (Residents M and N), who were in close contact with other residents positive for COVID-19, were moved onto another unit into rooms with residents (Q and S) who had no signs or symptoms and no previous known contact with positive COVID-19 cases, Resident N then tested positive for COVID-19 on [DATE], creating the increased risk of further spread of COVID-19 throughout the facility. The immediate jeopardy began on [DATE] when multiple residents were exhibiting symptoms consistent with COVID-19 but were not monitored and/or isolated. The Corporate Nurse, Regional Vice President of Operations, Executive Director, and Director of Nursing were notified of the immediate jeopardy on [DATE] at 1:35 p.m. The immediate jeopardy was removed on [DATE], but noncompliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: During an interview, on [DATE] at 1:30 P.M., the ED (Executive Director) indicated the facility had a total of 39 confirmed COVID-19 cases to date, including 2 deaths (one at the local hospital and one in the ambulance outside the facility) and 2 residents currently at the local hospital. She indicated Resident H expired in the ambulance in front of the building and Resident J had expired at the hospital. She indicated the hospital had contacted the facility on [DATE] in regard to Residents H and J with concerns of a COVID-19 outbreak and wanted to complete testing in the facility. The local hospital and the local health department tested all residents on the first floor of the facility (North, East, West and Dementia units) on [DATE]. The ED indicated the COVID-19 positive units were the dementia unit and north hall, and the east and west units were negative for COVID-19. The ED indicated the emergency plan for COVID-19 was implemented in the facility on [DATE] with notification from the hospital that Resident J was positive; he expired on [DATE] at the hospital. Review of the ISDH facility reporting tool as of [DATE] indicated the facility had reported to ISDH the positive COVID-19 result for Resident J on [DATE], but had not reported to ISDH the COVID-19-related deaths of Resident H or Resident J or any other residents positive for COVID-19. Review of an order signed by the State Health Commissioner, dated [DATE], and included in the ISDH LTC (Long Term Care) Newsletter, dated [DATE], included the requirement for COVID-19 reporting for long-term care facilities, prisons, jails, and other congregate housing. Effective Friday, [DATE], long-term care facilities were required to report the following within 24 hours: Any resident who tests positive for COVID-19; Any employee who tests positive for COVID-19; Any confirmed positive COVID-19 related death OR suspected COVID-19 related death of a resident; Any confirmed positive COVID-19 related death OR suspected COVID-19 related death of an employee. Confirmed or suspected deaths should be reported regardless of where the death occurred and within 24 hours of the facilities' knowledge of the death. During an observation, on [DATE] from 1:55 P.M. to 2:15 P.M., the north hall and the dementia unit were observed. The north unit was closed off with fire doors. The doors of residents' rooms were opened, and residents were observed in their rooms. Resident D and Resident F were observed lying in their beds. During this observation, RN 2 indicated all residents on this unit were positive for COVID-19 (total of 10), and there was one resident per room. She indicated Residents D and F were not doing well. The dementia unit was secured with fire doors, residents were observed wandering in the halls and many residents were in their rooms. The majority of the doors were open. Resident E's door was closed. During this observation, RN 3 indicated the staff was not aware of who was positive for COVID-19 and who was not. RN 3 indicated they were to treat everyone as if they were infected. During an interview, on [DATE] at 2:15 P.M., the DON (Director of Nursing) indicated all residents on the dementia unit had tested positive for COVID-19 except for two (Residents M and N) who were being moved off the unit as of this day (24 residents positive with two currently at hospital for a total of 26). 1. The record for Resident M was reviewed on [DATE] at 2:30 P.M. An infectious disease laboratory result, dated [DATE], indicated Resident M had tested negative for COVID-19. A progress note, dated [DATE] at 11:23 A.M., indicated the physician had been notified of the COVID-19 results. During an interview, on [DATE] at 5:00 P.M., the ED (Executive Director) indicated Resident M was one of only two residents who did not test positive for COVID-19 on the dementia unit (all residents on the unit were tested on [DATE]). She indicated Resident M had been moved off the dementia unit and had been placed in a room with a resident who was asymptomatic on a unit with no COVID-19 positive residents on [DATE]. She indicated she had been moved in with Resident Q on the first floor, West unit. Resident M was not isolated for 14 days after being in close contact with other residents who were symptomatic or had confirmed COVID-19. The resident had been exposed to her roommate who tested positive for COVID-19 and other residents on the dementia unit, for three days after being tested , from [DATE] to [DATE], when moved to the other room on another unit. 2. The record for Resident N was reviewed on [DATE] at 2:45 P.M. An infectious disease laboratory result, dated [DATE], indicated Resident N had tested negative for COVID-19. During an interview, on [DATE] at 5:00 P.M., the ED (Executive Director) indicated Resident N was one of the only two residents who did not test positive for COVID-19 on the dementia unit. She indicated Resident N had been moved off the dementia unit and had been placed in a room with a resident who was asymptomatic on a unit with no COVID-19 positive residents on [DATE]. She indicated she had been moved in with Resident S on the first floor, East unit. Resident N was not isolated for 14 days after being in close contact with other residents who were symptomatic or had confirmed COVID-19. The resident had been exposed to her roommate who tested positive for COVID-19 and other residents on the dementia unit, for three days after being tested , from [DATE] to [DATE], when moved to the other room on another unit. Review of an infectious disease laboratory result, dated [DATE], indicated Resident N had tested positive for COVID-19. Resident N had been in the same room with Resident S on a COVID-19 negative unit for two days at this time. During an interview, on [DATE] at 11:28 A.M., the ED indicated additional residents were tested on [DATE], and there were 17 more positive cases in the facility. Resident N was moved back to the dementia unit. During interview, on [DATE] at 1:45 P.M., the ED indicated, after receiving the additional test results, the residents who tested negative on the first floor, but had been in close contact with residents who recently tested positive, were moved upstairs on [DATE] to the third floor into rooms with roommates who were negative and had not been previously exposed. She indicated she did not have time, and they needed off the COVID-19 positive units. ISDH Guidance for out of hospital facilities, dated [DATE] and included in the COVID-19 Toolkit for Long Term Care, which was provided to the facility by an ISDH LTC Surveyor on [DATE], indicated the following: Patients with close contact with a confirmed COVID-19 patient (e.g., roommate or infected staff without wearing PPE) should be isolated and follow 14 day self-monitoring guidelines outline by CDC https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-longterm-care-facilities.html. If they develop symptoms, and are confirmed or suspected to have COVID-19, they should remain in isolation until at least 14 days after illness onset or 72 hours after resolution of fever, without use of antipyretic medication, and improvement in

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) symptoms (e.g., cough) whichever is longer. CDC's Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, included in the COVID-19 Preparedness Checklist for Nursing Homes and other Long Term Care Settings within the COVID-19 Toolkit for Long Term Care, which was provided to the facility on [DATE], was accessed on [DATE] at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html and included the following: Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, prioritize for testing, transfer to COVID-19 unit if positive). Closely monitor roommates and other residents who may have been exposed to an individual with COVID-19 and, if possible, avoid placing unexposed residents into a shared space with them. The COVID-19 Toolkit for Long Term Care was updated and distributed again electronically on [DATE], and the above information remained the same. 3. On [DATE] at 4:30 p.m., review of the Surveillance Log of Resident Infections and Antibiotic Use, dated [DATE], indicated Resident B presented with temperature, cough, and congestion with chest x-ray indicating possible pneumonia, and Resident C presented with shortness of breath, decreased oxygenation, labored breathing, and unresponsive. Review of the Surveillance Log of Resident Infections and Antibiotic Use, dated [DATE], indicated Resident D presented with a cough and fever, Resident E presented with a temperature, decreased oxygen saturation and diminished lung sounds, and Resident F presented with complaints of being weak and dizzy, shortness of breath and nonproductive cough. The LTC Respiratory Surveillance Line Listing, dated [DATE] to [DATE], was reviewed at 4:34 P.M. on [DATE]. The line listing indicated 7 residents had presented with respiratory symptoms, myalgia (muscle aches) or fever. Resident P presented with fever, myalgia and labored breathing on [DATE]. Resident B presented with cough on [DATE], per MD not testing for COVID-19. Resident G presented with fever and myalgia on [DATE], with no documentation of testing. Resident C presented with cough and shortness of breath, no date indicated, COVID-19 test negative. Resident D presented with cough on [DATE], per MD not tested for COVID-19. Resident E presented with a fever on [DATE] and shortness of breath, per MD not tested for COVID-19. Resident J had symptom onset on [DATE], but no specific symptoms were indicated. These surveillance listings indicated several residents were presenting with symptoms consistent with COVID-19 between [DATE] and [DATE]. Their records, as well as the records of four additional residents who developed symptoms after [DATE], were reviewed. The record for Resident B was reviewed on [DATE] at 4:35 P.M. The [DIAGNOSES REDACTED]. The resident resided on the first floor, west unit. A progress note, dated [DATE] at 3:10 P.M., indicated Resident B was admitted to the facility from a local hospital. Documentation did not indicate the resident was isolated for 14 days following admission from a hospital. A progress note, dated [DATE] at 11:07 A.M., indicated Resident B presented with a temperature of 99.3 and cough. The physician was notified and an order for [REDACTED].M., indicated Resident B's chest x-ray result was discussed with the physician, and the resident was placed in droplet isolation. A progress note, dated [DATE] at 3:50 P.M., indicated the facility had called the local State Agency epidemiology department at the request of the physician to review Resident B's symptoms. Epidemiology had indicated it was up to the physician to decide if COVID-19 testing should be completed. A progress note, dated [DATE] at 5:44 P.M., indicated Resident B had a new order to discontinue droplet precautions. A progress note, dated [DATE] at 12:33 A.M., indicated Resident B had an occasional cough noted. A progress note, dated [DATE] at 2:49 P.M., indicated Resident B had an occasional dry cough. A progress note, dated [DATE], indicated Resident B had a nonproductive cough noted. A progress note, dated [DATE] at 11:44 A.M., indicated Resident B continued on antibiotic for upper respiratory infection. A progress note, dated [DATE] at 11:25 A.M., indicated Resident B was discharged home. A review of the bed board from [DATE] to [DATE] indicated Resident B was in a room with a roommate. During an interview, on [DATE] at 4:20 P.M., the DON indicated COVID-19 testing had not been completed on residents that presented with symptoms, because the physician had not ordered the testing. During an interview, on [DATE] at 5:00 P.M., the ED indicated she was not aware of any residents who required COVID-19 testing prior to [DATE]. She indicated Resident B was admitted to the facility on [DATE], and the 14-day quarantine on new admissions did not get implemented until [DATE]. During an interview, on [DATE] at 12:36 P.M., the resident's physician, who was also the facility's Medical Director, indicated Resident B had potential symptoms of COVID-19, and he had requested the facility to notify the local state agency. He indicated Resident B was not tested for COVID-19, because he was told residents had to be sent to the hospital for testing. He indicated Resident B was removed from droplet precaution isolation on [DATE] when his chest x-ray indicated pneumonia. CDC guidance, Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19), originally dated [DATE] and last updated [DATE], was accessed at https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html on [DATE] and included the following: Clinicians should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested . Most patients with confirmed COVID-19 have developed fever and/or symptoms of acute respiratory illness (e.g., cough, difficulty breathing). Priorities for testing include: .PRIORITY 2 Ensure that those who are at highest risk of complication of infection are rapidly identified and appropriately triaged: Patients in long-term care facilities with symptoms Patients [AGE] years of age and older with symptoms Patients with underlying conditions with symptoms. Review of guidance from CMS, ISDH and CDC included the following: A CMS memo QSO-,[DATE]-NH, dated [DATE], and included in ISDH LTC (Long Term Care) Newsletter, dated [DATE], included, Facility staff should regularly monitor the CDC website for information and resources (links below). They should contact their local health department if they have questions or suspect a resident of a nursing home has COVID-19. Per CDC, prompt detection, triage and isolation of potentially infectious residents are essential to prevent unnecessary exposures among residents, healthcare personnel, and visitors at the facility. Therefore, facilities should continue to be vigilant in identifying any possible infected individuals. Facilities should consider frequent monitoring for potential symptoms of respiratory infection as needed throughout the day. The guidance, dated [DATE], also included, Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present. Also, if 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). Review of the ISDH LTC Newsletter registrants, indicated the facility's corporate Regional Vice President of Operations was registered and receiving the ISDH LTC Newsletters. 4. The record for Resident C was reviewed on [DATE] at 4:45 P.M. The [DIAGNOSES REDACTED]. The resident resided on the first floor, east unit. A progress note, dated [DATE] at 3:22 P.M., indicated Resident C had complained of a sore throat and cough with green sputum noted. A progress note, dated [DATE] at 12:10 A.M., indicated Resident C had an occasional cough noted. There was no documentation available for isolation precautions that were implemented or continued monitoring of these symptoms. A progress note, dated [DATE] at 10:03 A.M., indicated Resident C was noted to have difficulty breathing, difficult to arouse. Her oxygen saturation was less than 90% and she was started on oxygen at 2 liters, lung sounds were diminished to bilateral lower lobes. A progress note, dated [DATE] at 1:08 P.M., indicated Resident C's biox (oxygen saturation) dropped and she presented with [MEDICAL CONDITION] A new order for [MEDICATION NAME] (nebulizer treatment) was received and administered. A progress note, dated [DATE] at 3:04 P.M., indicated Resident C was verbally non-responsive and was on 3 liters of oxygen. A progress note, dated [DATE] at 3:33 P.M., indicated Resident C was sent out to the local hospital. A progress note, dated [DATE] at 12:22 P.M., indicated Resident C was admitted to the local hospital for acute [MEDICAL CONDITION]. A progress note, dated [DATE] at 7:23 P.M., indicated Resident C was admitted back to facility with right lower lobe infiltrate (pneumonia). There were multiple progress notes, dated [DATE] through [DATE], that indicated Resident C was non-compliant with the 14 day quarantine following hospitalization and had to be redirected back to her room multiple times. 5. The record for Resident D was reviewed on [DATE] at 3:00 P.M. The [DIAGNOSES REDACTED]. The resident resided on the North hall on the first floor. A progress note, dated [DATE] at 11:19 A.M., indicated Resident D had received a new order for [MEDICATION NAME] Perle (cough medicine) 100 mg (milligrams) three times daily for 7 days and for [MEDICATION NAME] nasal spray (for nasal congestion). A progress note, dated [DATE] at 8:30 P.M., indicated Resident D had broken the social distancing precaution and sat in the dining room with other residents playing Dominos. He had no signs or symptoms of respiratory infection, no cough or running nose. A progress note, dated [DATE] at 9:34 P.M., indicated Resident D was non-compliant with social distancing and was in the dining room with other residents; none were wearing masks. A progress note, dated [DATE] at 4:19 P.M., indicated [MEDICATION NAME] Perle was administered with positive effects. A nonproductive cough and hoarse voice was noted. A progress note, dated [DATE] at 4:46 P.M., indicated a new order for chest x-ray. A physician order, dated [DATE], indicated Resident D was placed in droplet isolation due to having an active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission related to fever and cough. A progress note, dated [DATE] at 10:12 A.M., indicated Resident D was in droplet isolation precautions and had a temperature of 99.2. A progress note, dated [DATE] at 4:11 P.M., indicated Resident D had elevated temperature and was noted to be perspiring. A progress note, dated [DATE] at 8:28 P.M.,

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) indicated Resident D had a temperature of 100.4 and was noncompliant with droplet isolation and social distancing. A progress note, dated [DATE] at 3:31 P.M., indicated a new order for [MEDICATION NAME] twice daily for 10 days for [MEDICAL CONDITION] exacerbation. A progress note, dated [DATE] at 1:55 P.M., indicated Resident D had a temperature of 101.4, and complained of not feeling well with lethargy noted. Lung sounds were diminished on the right and oxygen saturation was ,[DATE]%. An infectious disease lab result, dated [DATE], indicated Resident D had COVID-19 detected. The physician was notified on [DATE] at 7:00 P.M. A progress note, dated [DATE] at 3:40 P.M., indicated Resident D presented with poor appetite and oxygen saturation of 87%. During an interview, on [DATE] at 1:38 P.M., the DON indicated Resident D was not placed in droplet precautions on [DATE] when symptoms of cough and nasal congestion were noted because he did not have a fever. She indicated it was the policy of the facility to inform the physician of signs and symptoms, and it was at the physician's discretion if the residents were placed in isolation. During an observation, on [DATE] at 2:20 P.M., Resident D was lying in bed, asleep, with the door to the room open. A review of the bed board from [DATE] to [DATE] indicated Resident D was in a room with a roommate. The COVID-19 Toolkit for Long Term Care, which was provided to the facility on [DATE], indicated all LTC facilities who have not already done so, need to use the CDC COVID-19 Preparedness Checklist for Nursing Homes and other Long Term Care Settings to prevent the spread of coronavirus in their facilities. This checklist included: Identification and Management of Ill Residents: The facility has a process to identify and manage residents with symptoms of respiratory infection (e.g., cough, fever, sore throat) upon admission and daily during their stay in the facility which include implementation of appropriate Transmission-Based Precautions. The facility has criteria and protocol for initiating active surveillance for respiratory infection among residents and healthcare personnel. On [DATE] at 5:00 P.M., the Corporate Nurse provided the COVID-19 Resident Policy (replaces interim COVID-19 policy), dated [DATE] (revised [DATE], [DATE] & [DATE]), which indicated a resident with suspected or confirmed COVID-19 would be placed on Droplet Precautions and signs would be placed outside of the patient's door. Resident room placement would occur only under the direction of the IDT team and Infection Preventionist. The door should remain shut except when entering and exiting the room. 6. During an interview, on [DATE] at 1:45 P.M., RN (Registered Nurse) 3 indicated Resident E was not doing well. The record for Resident E was reviewed on [DATE] at 3:45 P.M. The [DIAGNOSES REDACTED]. Resident E was documented as a full code. The resident resided on the dementia unit on the first floor. A progress note, dated [DATE] at 10:41 P.M., indicated Resident E had a fever of 102 and chest x ray was ordered. There was no documentation of any isolation precautions at this time. A progress note, dated [DATE] at 12:41 P.M., indicated a new order was received to place Resident E in droplet isolation precautions. A progress note, dated [DATE] at 2:15 P.M., indicated Resident E's chest x-ray results indicated multifocal bilateral [MEDICAL CONDITION] infiltrates. A progress note, dated [DATE] at 5:38 P.M. indicated Resident E was observed on the bedroom floor near bathroom entrance and he was too weak to stand. An Infectious Disease lab result, dated [DATE], indicated Resident E had COVID-19 detected. A progress note, dated [DATE] at 11:14 A.M., indicated Resident E's oxygen saturation was 77% and he was placed on oxygen mask at 6 liters. A progress note, dated [DATE] at 11:17 A.M. indicated Resident E's family was notified on [DATE] that he was positive for COVID-19. A progress note, dated [DATE] at 2:44 P.M., indicated Resident E's pulse was 42 and biox was 77%. Head of bed was elevated and oxygen mask at 10 liters was applied. A progress note, dated [DATE] at 8:35 A.M., indicated Resident E was placed on a non-breather mask at 15 liters and oxygen saturation was ,[DATE]%. A progress note, dated [DATE] at 1:18 P.M., indicated Resident E continued to be restless and oxygen saturation was 84% on 6 liters and resident was non-compliant with rebreather. Physician was notified and resident was send out to local hospital due to being a full code. A history and physical, dated [DATE], indicated Resident E had reportedly had a cough, congestion, and fever up to 102 since [DATE]. He continued to have progressive worsening, [MEDICAL CONDITION] requiring up to 6 liters of oxygen. He continued to have shortness of breath, progressive [MEDICAL CONDITION] and was restless. Upon admission he required 12 liters of oxygen on a non-rebreather mask. The emergency room report, dated [DATE], indicated the physician had spoken with power of attorney and Resident E was changed to a Do Not Resuscitate from a full code. [DIAGNOSES REDACTED]. A discharge summary, dated [DATE], indicated Resident E was admitted for [MEDICAL CONDITION] on [DATE]. He did test positive for COVID-19 and currently resided in nursing facility that had a severe outbreak of [MEDICAL CONDITION]. He was found to have pneumonitis versus possible pneumonia in the setting of COVID infection. Upon observation, patient was breathing very heavily using his abdominal muscles, he was unable to follow any commands and he was not alert. Patient was actively dying. The Discharge summary, dated [DATE], indicated Resident E expired at 11:38 A.M. and primary cause of death was [DIAGNOSES REDACTED]-COv2 (COVID-19) [MEDICAL CONDITION] pneumonia. A review of the bed board from [DATE] indicated Resident E was in a room with a roommate; the other resident was moved out on [DATE]. During an interview, on [DATE] at 4:40 P.M., the resident's physician/Medical Director indicated he had been told the COVID-19 testing was not being completed in the facility, and he just found out that there was a task force that would come do the testing in the facility last week. He indicated if testing had been allowed in the facility, he would have tested Resident B and Resident E for sure. He indicated the facility had told him that residents had to be sent out to the hospital to be tested for COVID-19. During an interview, on [DATE] at 4:50 P.M., the DON indicated that it was the facility's policy to send residents to the hospital for testing; there were no tests completed in the facility prior to [DATE]. Review of the ISDH LTC Newsletter, dated [DATE], included information regarding LTC Strike Teams who would be going to facilities to provide PPE training, communicate risk mitigation strategies with essential staff and do targeted COVID-19 test collection. The ISDH LTC Newsletter, dated [DATE], included a COVID-19 Toolkit for facilities. A copy of this toolkit, as well as information for the LTC Newsletter, was provided to the facility by an ISDH LTC surveyor on [DATE]. This toolkit included information regarding the ISDH teams available to come into facilities to rapidly test residents and staff who are suspected of having COVID-19. It instructed facilities who have residents or providers who are symptomatic and need to be tested , to contact the COVID-19 Outbreak Response Logistics Coordinator and included contact information. The toolkit also included contact information at ISDH if the facility would like to discuss the need for testing at the facility or COVID-19 prevention such as PPE donning and doffing. 7. The record for Resident F was reviewed on [DATE] at 3:50 P.M. The [DIAGNOSES REDACTED]. The resident resided on the North hall on the first floor. A progress note, dated [DATE] at 11:10 A.M., indicated Resident F was weak and dizzy with moist non-productive cough and complained of shortness of breath. His oxygen saturation was 86% and oxygen at 2 liters was applied. There was no documentation of droplet isolation precautions implemented with cough and complaints of shortness of breath. An Infectious Disease lab result, dated [DATE], indicated Resident F had COVID-19 detected. There was no documentation of droplet isolation precautions implementation. A progress note, dated [DATE] at 4:05 P.M., indicated social service had notified a family member of possible room move. A progress note, dated [DATE] at 1:03 P.M., indicated Resident F was on 4 liters of oxygen and complained of shortness of breath with labored breathing. A progress note, dated [DATE] at 6:22 P.M., indicated Resident F had cough and labored breathing noted. He was using accessory muscles to breathe, mouth breathing with slight nasal flare when exhaling and complained of shortness of breath. Biox was 95% on 5 liters of oxygen. Physician was notified with orders to continue to monitor. Family was notified and wanted resident sent out to local emergency room if condition worsened. A progress note, dated [DATE] at 10:02 P.M., indicated Resident F was sent to the local emergency room at 8:00 P.M. Resident had shrill cough and labored breathing noted and indicated he was having trouble breathing, using accessory muscles to breath. Oxygen was at 5 liters per nasal cannula, oxygen saturation was 91% and respirations were 44. A History and Physical, dated [DATE], indicated Resident F had presented with respiratory status over the past 5 days and tested positive for COVID-19 at facility. He was unable to contribute any information as Resident F was breathing hard and not answering questions. Assessment indicated COVID pneumonia and now a health-associated pneumonia. Daughter was notified of prognosis and agreed to a Do Not Resuscitate-Do Not Intubate and that he will likely not have a good outcome. The ER Physician Report, dated [DATE], indicated Resident F presented with breathing difficulty with onset 5 days ago. The course/duration of symptoms was constant. Degree at onset moderate. Degree at present severe. Present to ER with gradually worsening difficulty breathing, had already been diagnosed with [REDACTED]. The daughter was notified that given the situation and diminished likelihood that he would survive on a ventilator, she elected to make him a no code and no intubation. The Discharge summary, dated [DATE], indicated Resident F was found to be COVID positive when he came to the ER, and chest x-ray showed some patchy airspace disease in the mid to lower lungs that was suspicious for infiltrate. Unfortunately, his respiratory status did decline rapidly. He received high-flow oxygen and continued to deteriorate. The decision was made in line with the patient's family wishes that patient be made a DNR and on end of life care, comfort measures. Resident F succumbed to his medical illness and died on [DATE] at 5:15 P.M. Final [DIAGNOSES REDACTED]. A review of the bed board from [DATE] indicated Resident F was in a room with a roommate; the other resident was moved out on [DATE]. 8. The record for Resident H was reviewed on [DATE] at 4:00 P.M. The [DIAGNOSES REDACTED]. The resident resided on

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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 -** Some	(continued... from page 3) the first floor, east unit. A progress note, dated [DATE] at 6:01 P.M., indicated Resident H had confusion and restlessness noted. A progress note, dated [DATE] at 9:50 P.M., indicated Resident H had an unwitnessed fall. Resident was restless and confused, difficult to redirect during shift. A progress note, dated [DATE] at 6:11 A.M., indicated Resident H had been restless, getting up from wheelchair and walking without assistance. A progress note, dated [DATE] at 10:11 A.M., indicated Resident H ha