STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265849	A. BUILDING _____ B. WING _____	05/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MCKNIGHT PLACE EXTENDED CARE	TWO MCKNIGHT PLACE SAINT LOUIS, MO 63124

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** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to fully implement Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) recommended infection control practices, following the outbreak of a coronavirus disease 2019 (COVID-19, an infectious disease caused by severe acute respiratory syndrome coronavirus 2 ([DIAGNOSES REDACTED]-CoV-2)) pandemic, in order to control and/or prevent the potential spread of the disease among residents and staff. The facility failed to implement isolation precautions for one of six residents with possible symptoms of [MEDICAL CONDITION] (Resident #1) and released one recently readmitted resident from isolation after 11 days (Resident #2). The facility's policies did not address time frames for temporary isolation of residents. The census was 54. Review of the CDC guidance, updated 5/19/20, showed the following: -Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise (general feeling of discomfort/illness/uneasiness), headache, new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Identification of these symptoms should prompt isolation and further evaluation for COVID-19; -There is a higher risk for unrecognized infection among residents; -The facility should create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or a separate isolation area for monitoring for evidence of COVID-19. Residents could be transferred out of the observation area to the main facility, if they remain afebrile (without fever) and without symptoms for 14 days after admission. Testing at the end of this period could be considered for increased certainty; -Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least three times daily to identify and quickly manage a serious infection. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/17/20, showed the following: -Moderate cognitive impairment; -Wheelchair mobility; -Signs and symptoms of [MEDICAL CONDITION]: fluctuating inattention and disorganized thinking; -[DIAGNOSES REDACTED]. Review of the resident's undated care plan, showed an activities of daily living (ADL) deficit related to dementia and impaired balance. Review of the resident's progress notes, showed the following: -5/14/20 at 12:55 P.M., staff had a call out to the resident's physician pertaining to increased crackles and coarseness to lower, middle, and upper lobes (units of the lungs) which were audible with a stethoscope. Continuous cough. Weight between 84 pounds (lbs.) and 86 lbs. At 1:09 P.M., staff received a call back from the physician who ordered [MEDICATION NAME] (antibiotic) 500 milligrams (mg) daily times 10 days and [MEDICATION NAME] ([MEDICATION NAME]) 250 mg twice daily times two weeks; -5/15/20 at 12:33 P.M., the resident was on antibiotics for suspected pneumonia. Temperature 98.1 degrees Fahrenheit (F). Coarseness and crackles continued his/her in lower, middle and upper lobes. The resident's cough continued. Oxygen saturation 97%; -5/16/20 at 10:37 P.M., he/she remained on antibiotics for upper respiratory infection. He/she had a productive cough, but was able to spit it out after he/she expectorated it. The resident's phlegm at times was yellow to pale white and clear. He/she remained afebrile with a temperature of 98.0 degrees F. The resident's respirations were even and unlabored. All other vital signs were stable. His/her oxygen saturation (registered) 92% on room air; -5/20/20 at 12:47 P.M., the resident's temperature was 97.9 degrees F. He/she continued to have a slight non-productive cough with congestion. At 6:22 P.M., the resident had audible wheezing and congestion. His/her temperature was 97.5 degrees F; -5/21/20 at 11:49 A.M., he/she was on antibiotics for pneumonia until 5/23/20. His/her temperature measured 97.5. The resident continued to have a non-productive cough with congestion in all lung fields. During an interview on 5/26/20 at 12:03 P.M., the Director of Nursing (DON) said the resident was not considered for isolation, because his/her respiratory issues were chronic. 2. Review of Resident #2's significant change MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Walker and wheelchair mobility; -Acute change in mental status from baseline; -Sign and symptom of [MEDICAL CONDITION]: fluctuating inattention; -[DIAGNOSES REDACTED]. Review of the resident's undated care plan, showed the resident had an ADL self-care performance deficit related to lack of motivation and judgement, chronic pain, memory deficits and anxiety. Review of the resident's progress notes, showed the following: -3/19/20 at 7:32 P.M., resident left the facility via ambulance going to the hospital at 7:32 P.M. He/she had low hemoglobin (Hgb, which helps transport oxygen from the lungs throughout the body. Low Hgb indicates [MEDICAL CONDITION]), low hematocrit (hct, proportion of the blood consisting of red blood cells. Low hct indicates [MEDICAL CONDITION]) and elevated white blood cell count (indicates an infection) from lab results, [DIAGNOSES REDACTED].M., the resident arrived from the hospital with a runny nose, [MEDICAL CONDITION] (abnormal heartbeat), and was attempting to get out of bed; -3/30/20 at 10:34 P.M.,the resident's last day on isolation. 3. Review of the facility's Infection Control Guidelines for All Nursing Procedures, revised April 2013, showed transmission-based precautions were to be used whenever measures more stringent than standard precautions were needed to prevent the spread of infection. In addition to the general guidelines specified in the policy, staff was to refer to procedures for any specific infection control precautions which may be warranted. Further review of the facility's Infection Control Guidelines for All Nursing Procedures, revised April 2013, showed no guidance specifying what transmission based precautions should be employed or under what circumstances they should be employed. No procedures for specific infection control precautions which may be warranted were detailed. The policy did not explain which supplemental policies or procedures staff should consult. 4. Review of the facility's Coronavirus 2019 Disease (COVID-19) Preparedness and Response Policy & Procedure, showed that if a resident developed one or more of the common COVID-19 symptoms (fever, cough, shortness of breath), the resident should be considered for isolation. The nursing staff should consider other common etiologies for any new symptoms (e.g. allergies [REDACTED]. Isolation would be immediately recommended, if there was a history of a positive COVID case in the facility or the resident with new symptoms has had exposure to someone who has tested positive for COVID and has had contact within the last 14 days. The need for isolation for each individual resident will be determined by the medical director, primary care physician, DON, and administrator. Further review of the facility's COVID-19 Preparedness and Response Policy & Procedure, showed no specification of periods for temporarily isolation and monitoring of new admissions and readmissions for symptoms, when COVID-19 testing has not been performed. The policy did not specify how long a newly admitted or readmitted resident must remain symptom free, before the isolation period could be terminated.

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.