STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455653	A. BUILDING _____ B. WING _____	**05/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SKYLINE NURSING CENTER	**3326 BURGOYNE DALLAS, TX 75233**

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 interview and record review, the facility failed to notify the resident representative when there was a significant change in the resident's physical, mental or psychosocial status and when there was a decision to transfer the resident from the facility for three (Residents #6, #7 and #8) of five residents reviewed for resident rights. The facility failed to notify the responsible parties of Residents #6, #7 and #8 when they were transferred to the hospital for a change in condition related to sign/symptoms of COVID-19. This failure could place residents at risk of not having their responsible party notified of changes, resulting in a delay in medical intervention and decline in health . Findings included: 1) Review of Resident #6's Significant Change MDS assessment dated [DATE] revealed she was an [AGE] year old female originally admitted on [DATE] and re-admitted on [DATE]. Resident #6's active [DIAGNOSES REDACTED]. Her BIMS score was a 6 which indicated severe cognitive impairment. Review of Resident #6's face sheet, undated, reflected her family member was documented as her emergency contact and responsible party. Review of Resident #6's advanced directives listed the RP as Resident #6's medical power of attorney. Review of Resident #6's change in condition nursing note revealed around 8:15 PM on [DATE], the nurse took Resident #6's vitals and she had a temperature of 101.3 degrees Fahrenheit. The nurse notified the DON and the doctor, and an order was given to send the resident to the ER. The resident left the facility at 9:46 PM for an evaluation. The nursing note did not indicate the resident's responsible party was notified. An interview with the responsible party (RP) of Resident #6 on [DATE] at 3:33 PM revealed Resident #6 was transferred to the hospital on [DATE]. The RP stated he had been trying to call Resident #6 that evening and she did not answer her cell phone. The next morning, [DATE], he woke up and tried to call her again, but there was still no answer. He called the facility and the front desk attendant said she could not go onto the floor because it was blocked off. The RP asked for the nurse, who said he could not leave the floor. The RP asked for the nurse to call him back. He waited an hour and there was no call back, so he went to the facility. The front desk staff told the family member he had to talk to the ADM. When the ADM arrived, the RP said he did not know where Resident #6 was. He said the ADM thought the family member had been notified that Resident #6 had been sent to the hospital. He said the ADM told him he was sorry and that someone dropped the ball and he was going to address it. The RP said he was frustrated because no one had called to notify him the night prior. He said he went to the hospital where the facility had sent her and he could not see her due to the prevention of visitors at the hospital from the COVID-19 virus. He said he was only able to talk to Resident #6 through a phone at the nurses' station. When he was able to talk to her on the phone, he tried to tell her everything was okay. The RP said Resident #6 died on [DATE]th, 2020. He said, We just buried her today. He said she had tested positive for COVID-19 virus. He said, I never got a chance to see her until yesterday when I went to view her body. I am the only child, I am supposed to be aware of what is going on. They were supposed to call me. Interview with the ADM on [DATE] at 3:11 PM revealed the RP/MPOA of residents were supposed to be notified by the facility when there was a change in condition or when the resident was being sent out to the hospital. The ADM admitted there was a slight delay in notifying Resident #6's family. He said he remembered talking to her family member/RP the day after she was sent to the hospital, but thought it was the hospital who notified the family. Interview with the ADON on [DATE] at 4:10 PM revealed the nurse who failed to notify the family for Resident #6 was a new nurse. She said her expectation for the nurses was they contacted the RP/MPOA when there was a change in condition and when a resident was being sent out to the hospital, right after the doctor was notified and ordered the transfer. 2) Review of Resident #7's Admission MDS assessment dated [DATE] revealed he was a [AGE] year old male admitted on [DATE]. Resident #7's active [DIAGNOSES REDACTED]. His BIMS score was a 10 which indicated moderate cognitive impairment. Review of Resident #7's face sheet, undated, reflected he had a guardian who was also his responsible party. Review of Resident #7's nursing progress note dated [DATE] at 3:30 PM revealed Resident #7's RP called to check on him. The nurse told the RP that Resident #7 was sent out to the hospital the night prior due to an elevated temperature. The nurse documented, (RP) got upset demanding and asking more questions, the nurses on duty apologized to her, and she states that's ok but that's unprofessional, further she will talk to somebody. Interview with Resident #7's RP on [DATE] at 4:41 PM revealed Resident #7 went to the hospital because he got ill, he was running a fever and was not feeling well. She said he had not been tested for COVID-19 before he was sent out, even though the facility already had 20 cases. She said the facility did not notify her they were sending him out. She said she just happened to call to try and speak to the resident, it took a long time and she was on hold for 20 minutes. They finally came back and said he was taken to the hospital. The RP said, I said what hospital, no one called me? The facility told her he left on a Friday and she found out the following Saturday afternoon. She said they just apologized and the ADM told her the nurse should have notified her, They act like it wasn't protocol. My brother cannot make his own choices/consent, I am his guardian. She said she still had not been able to see her brother because he was in quarantine and had been since being moved to a group home She said she found out from the hospital that he had tested positive for COVID-19. 3. Review of Resident #8's Quarterly MDS assessment dated [DATE] revealed he was a [AGE] year old male admitted on [DATE]. Resident #8's active [DIAGNOSES REDACTED]. He had unclear speech and was rarely understood. He had short and long-term memory issues and he was severely impaired in making decisions about his tasks of daily life. Review of Resident #8's face sheet, undated, reflected he had a responsible party, next of kin, care conference person and emergency contact. Review of a nursing note for Resident #8 dated [DATE] at 6:35 AM revealed a CNA notified the nurse that the resident felt hot. His temperature was taken, and it was 102.1 degrees Fahrenheit. The doctor was notified, and an order was made for a stat chest x-ray and stat CBC, CMP. Resident #8 was moved to another room and put into isolation precautions. At 7:31 AM, Resident #8's blood pressure was ,[DATE], pulse was 120 bpm, respirations were 20 and his fever remained at 102.1 degrees Fahrenheit. The doctor said he would need to be sent to the hospital. There was no documentation in the nursing notes that the RP/MPOA was notified of the change in condition and transfer. Interview with the RP for Resident #8 on [DATE] at 1:52 PM revealed a hospital doctor called him around 3:30 PM on a Friday and told him the resident had been running a fever and the facility sent him to the hospital the day prior. He said the facility never notified him that the resident was being sent out. The RP said, I am thinking well, how did he get out there, no one called me, the doctor did not know no one talked to me. To be honest, if you have to take a person to the hospital, you must be concerned, so in that case I should have been notified. He said he did not want the resident to return to the facility because of the inappropriate way they handled the transfer to the hospital. He said, If you can't do minor things, then it puts major things into question. He said the facility did end up apologizing to him for the failure to notify him but did not give him a reason why. He said, I was appalled they didn't let me know because my brother cannot talk. Interview with the DON on [DATE] at 12:39 PM revealed when a resident was sent to the ER, the charge nurse had to notify the DON and the administrator was notified. She stated they also notified the family as long as the resident was not their

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

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F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) own responsible party. Interview with the ADON on [DATE] at 2:03 PM revealed when a resident was sent to the hospital, the nurse on duty did a Change of Condition Form and a transfer form, notified the emergency transport company, the administrator and family. Interview with LVN E on [DATE] at 4:30 PM revealed when a resident was transferred to the hospital from the facility, the responsible party should be notified. She said she would notify them as soon as she could, They need to know because God forbid they go to hospital and someone doesn't make it. Review of the CMS Resident Rights and Protections Policy indicated, The nursing home must notify your doctor and, if known, your legal representative or an interested family member when the following occurs: You're involved in an accident and are injured and/or need to see a doctor; Your physical, mental, or psychosocial status starts to get worse; You have a life threatening condition; You have medical complications; Your treatment needs to change significantly; The nursing home decides to transfer or discharge you from the nursing home. (retrieved [DATE], www.cms.gov).
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet a resident's medical, nursing and mental and psychological needs for three (Residents #9, #10 and #11) of three residents whose care plans were reviewed for accuracy. The facility failed to update Residents' #9, #10 and #11's acute care plans when they had a change in condition (COVID-19 19 positive status) and were prescribed [MEDICATION NAME] (immunosuppressive drug and anti-parasite) for short-term off label use and [MEDICATION NAME] (antibiotic). This failure could place residents at risk of receiving inadequate interventions not individualized to their mental health care needs. Findings included: 1) Review of Resident #9's admission MDS assessment dated [DATE] reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His active [DIAGNOSES REDACTED]. He had no cognitive impairments. He required [MEDICAL TREATMENT] while a resident at the facility. Review of Resident #9's nursing notes revealed an infection control note on 04/17/20 which indicated Resident #9 was positive for COVID-19 and his pulse oximetry was reading 89-90% on room air and he was refusing to wear his O2. He also had multiple loose stools. The MD was informed of symptoms and a new order was received to start [MEDICATION NAME] 200 mg BID x 5 days and [MEDICATION NAME] 500 mg daily x 5 days for COVID-19-19. Review of Resident #9's MAR for April 2020 revealed he was in the process of being administered the medications as prescribed. Review of Resident #9's care plan initiated on 02/18/20 did not reflect that he was prescribed a round of [MEDICAL CONDITION]/antibiotic medications for a potentially deadly virus (COVID-19) nor the potential harmful side effects to monitor for. 2) Review of Resident 10's admission MDS Assessment reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His active [DIAGNOSES REDACTED]. His BIMS score was an 11, indicating mild cognitive impairment. Review of Resident #10's nursing note revealed an infection control note dated 04/17/20 which indicated Resident #10 sating 89-91% on room air. He was removing his O2, saying he did not need it. A new order was received to start [MEDICATION NAME] 200 mg BID x 5 days and [MEDICATION NAME] 500 mg daily x 5 days for COVID-19 19. Review of Resident #10's MAR for April revealed he was in the process of being administered the medications as prescribed. Review of Resident #10's care plan initiated 03/19/20 did not reflect that he was prescribed a round of [MEDICAL CONDITION]/antibiotic medications for a potentially deadly virus (COVID-19) nor the potential harmful side effects to monitor for. 3) Review of Resident #11's quarterly MDS assessment dated [DATE] reflected he was an [AGE] year-old male admitted to the facility on [DATE]. His active [DIAGNOSES REDACTED].#11's nursing note revealed an infection control note dated 04/19/20 for [MEDICATION NAME] 200mg 1 tab by mouth two times a day for infection until 04/21/20. Review of Resident #11's MAR for April 2020 revealed he was in the process of being administered the medications as prescribed. Review of Resident #11's care plan last updated 03/17/20 did not reflect that he was prescribed a round of [MEDICAL CONDITION]/antibiotic medications for a potentially deadly virus (COVID-19) nor the potential harmful side effects to monitor for. 4) Review of the FDA Recommendations reflected, Recommended Laboratory and Monitoring Procedures .Severe [DIAGNOSES REDACTED]: [MEDICATION NAME] sulfate has been reported to decrease insulin clearance and resistance. Loss of consciousness in patients with or without the use of antidiabetic medications has been reported .Renal impairment: [MEDICATION NAME] sulfate is known to be substantially excreted by the kidney, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. (www.fda.gov, retrieved 04/21/20). 5) Interview with MDS Coordinator/LVN G on 04/21/20 at 3:52 PM revealed acute care plans were done by the ADON and were put directly into the electronic charting system. 6) Interview with ADON F on 04/21/20 at 4:10 PM revealed she did not know the potential negative side effects for the off-label use of [MEDICATION NAME] or what populations would be possibly adversely affected. The ADON said she, the DON and the charge nurses were responsible for updating care plans for acute issues. She said they had 48 hours to update the care plan for acute issues. She did not have a reason as to why the care plans for Residents #9, #10, and #11 on the antibiotic/[MEDICAL CONDITION] cocktail were not updated. 7) Review of the facility's Care Plan-Resident Policy dated May 2017 reflected, .5. Resident Goals (Short-term): a) List a measurable goal for each problem identified. Goals should be stated in terms of what the resident will or will not accomplish; .6. Approach/Plan: .c) Individualize care to ensure the care plan is person centered for the unique needs of the resident .
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observation, interview and record review, the facility failed to store all drugs and biologicals in locked compartments and to permit only authorized personnel to have access for one (Hall 700) of eight halls observed. The facility failed to ensure all medications were stored properly on Hall 700 which was one of two secured halls in the facility. These failures could affect residents by placing them at risk of ingesting unprescribed medications which could lead to adverse effects. Findings included: An observation on 04/22/20 at 6:11 PM revealed an orange medication pill was in the corner on the floor of Hall 700 next to the exit by the nurse's station. Interview with LVN ( ) on 04/22/20 at 6:12 PM revealed he was not sure what the pill was or where it came from. LVN ( ) stated he always made sure the residents took their medications especially since Hall 700 was a secured hall.
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 establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for eight (Halls 100, 200, 300, 400, 500, 600, 700 and 800) of eight halls reviewed for infection control, impacting all residents in the facility. 1, The facility failed to ensure Residents #1 and #3 were moved out of the COVID unit after their roomates' (Resident #2 and #4) tested tested positive for COVID-19 in Hall 400. 2. The facility failed to ensure Resident #1, #2, #3, #5, #7, #10, #12, #13 and #14 were monitored for signs and symptoms of COVID-19 on Halls 200, 400, 500, 600, 700 and 800. 3. The facility failed to ensure they had dedicated staff working on the three COVID-19 positive units (Halls 100, 400 and 800). 4. The facility failed to isolate five COVID-19 positive residents (Residents #16, #17, #18, #19 and #20) on the secure unit (Hall 700) from residents who were negative for COVID-19. 5. The facility and failed to ensure staff wore appropriate PPE when working with the residents positive for COVID-19 on Hall 400 and Hall 700. An Immediate Jeopardy (IJ) was identified on 04/20/20. The facility was provided with the IJ template on 04/20/20. While the IJ was lowered on 04/24/20, the facility remained out of compliance at a severity level potential for more than minimal harm that was not immediate jeopardy and a scope of widespread because the facility was still monitoring the effectiveness of their Plan of Removal. This failure could place residents at risk for exposure to, and failure to identify the COVID-19 virus and result in serious illness and/or death. Findings included: Review of the facility's COVID-19 testing log provided revealed Resident #1 had tested negative for [MEDICAL CONDITION]. However, his roommate (Resident #2) had tested positive on 03/30/20. Review of Resident #1's Admission Record, dated 04/22/20, revealed he was [AGE] years old and was originally admitted to the facility on [DATE]. Observation and interview

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) on 04/20/20 at 5:14 PM revealed Resident #1 was lying in bed. He stated he was not concerned with coronavirus and did not have a mask but would like to have one. Resident #2 was observed in the room with Resident #1. He was sitting in a chair eating his evening meal and was within six feet of his roommate. Review of the facility's COVID-19 testing log revealed Resident #3 had tested negative for [MEDICAL CONDITION]. However, her roommate, Resident #4, had tested positive on 03/30/20. Review of Resident #3's Admission Record, dated 04/23/20, revealed she was [AGE] years old and was originally admitted to the facility on [DATE]. Interview and observation on 04/20/20 at 6:31 PM of Resident #3 revealed she was sitting in her wheelchair at the entry of her room wearing a mask. The door to the room was open. Resident #3 stated she was tested for coronavirus on the same day as her roommate and her results were negative. Her roommate, Resident #4, was observed sitting up in bed. She was not wearing a face mask. Resident #4 stated she was tested positive for coronavirus 17 days ago and had not been retested . Resident #4 stated her mask was kept on the tray of her walker and she was told by staff that she only had to wear the mask whenever she left her room. Resident #4 was surprised when her roommate (Resident #3) said she had tested negative for coronavirus. Resident #4 said she thought her roommate (Resident #3) had tested positive for coronavirus as well since the two had remained roommates. An interview with the ADM on 04/20/20 at 2:25 PM revealed there were 32 COVID-19 positive residents in the facility. He said the COVID-19 positive residents were currently located on Hall A, Hall B and two residents on Hall C. He said everyone on Halls A and B was tested for COVID-19 and most of them were positive. The ADM stated they were directed by the health department not to move the residents who tested negative because those residents had been exposed to COVID-19 and moving them could expose other residents to [MEDICAL CONDITION]. He said the staff were using PPE and social distancing for all the residents to protect them and they encouraged residents to wear masks to the best of their ability. He said the staff were treating everyone on Halls A and B like they were positive. He said he did not want to move a resident who was negative only to have them test positive later. He said Hall C currently only had two residents. He said the rest of the beds were empty because it was being cleared out and reserved for COVID-19 positive patients admitting to the facility from the hospital under a special contract. The ADM was asked if he had re-tested Residents #1 and #3. He responded, I wish we could test them again, but we are focusing on the positive ones. He said the facility notified all family members of the test results for residents on Halls A, B and C and let them know their negative tested loved ones were still on isolation on those halls. The ADM said he did not tell the families of Residents #1 and #3 that they were in a room with a resident who was positive for COVID-19 because it could be a HIPAA violation. He said if a resident became exposed, they were supposed to be on isolation for 14 days. He said there was no way to quarantine Residents #1 and #3 on another hall without exposing them to other non-symptomatic residents. He said no residents in the two secure units had tested positive. He stated, We got aggressive with them immediately. Interview with MA A on 04/20/20 at 6:24 PM revealed she was in the hallway of the COVID-19 unit (Hall B) and was not wearing a gown or eye protection. She said she did not have to unless she was in a resident's room. She said she did not know which residents on the hall had tested positive or negative for COVID-19. She said oftentimes, the staff member she relieved had already left for the day by the time she got to the facility so there was no one to give her a report on the residents. She said she did not receive any training related to COVID-19 from the facility. Further interview with the ADM on 04/20/20 at 6:52 PM revealed the County Health Department had been the entity that told him not to move the COVID-19 negative residents from the rooms of their COVID-19 positive roommates. He said he was told verbally and did not have that directive in writing. He also stated he did not have any rooms available to move those COVID-19 negative residents to who had been exposed to their COVID-19 positive roommates. He said the residents in question were initially negative, but that test could return a false negative. He said there was a chance the COVID-19 negative roommates were now COVID-19 positive, but he had not had tests available to re-test them. The ADM said there currently was no plan to move COVID-19 negative Residents #1 and #3 off the COVID-19 positive units (Halls A and B). Interview with the ADM on 04/20/20 at 9:09 PM revealed there were no empty rooms available in Halls A and B to quarantine Residents #1 and #3. He re-iterated that Hall C was not available and that was why they were in the current position because the facility did not have available beds. The ADM said he was going to start accepting COVID-19 positive patients from the hospital and admit them to Hall C because they received a letter that stated they could proceed with new COVID-19 positive admissions. He said he was already getting calls from the hospital for placement. The ADM was asked why the facility did not move the COVID-19 negative residents into rooms together to quarantine. He responded some residents were simply oriented to their room and space and might go back to their old room. He also said it could be an issue of rooming together male/male, female/female beds only. He then said, We could move the five COVID-19 negative residents to Hall C, but we would be pushing back the plans to admit the COVID-19 positive residents here from the hospital. He was asked what the plan was for Residents #1 and #3. He replied they would stay on the COVID-19 isolation hall in their same rooms. He said, We don't know when they would get tested or come out of isolation. He stated it depended on when the lab and health department can test them. An interview on 04/21/20 at 1:31 PM with the local health department (HD) and the lead HD physician (PHY) for the county revealed the HD's recommendation was if it was feasible, to remove a roommate who was negative for COVID-19 to another room, away from their roommate who was positive for COVID-19. The PHY said if the facility was able to move the resident out who was negative, that would be best because, Maybe they have been exposed does not mean they are going to get it. She said if the positive/negative roommates had to stay in the same room, then hopefully, they were staying six feet apart. The PHY said, We try not to room positive negative together, we try to separate them out .But the roommate is essentially supposed to be quarantined for 14 days and be monitored for signs and symptoms. Review of the Centers for Disease Control and Prevention (CDC) Responding to Coronavirus (COVID-19) in Nursing Homes revealed: Resident with new-onset suspected or confirmed COVID-19 Place the resident in a single room if possible pending results of [DIAGNOSES REDACTED]-CoV-2 testing. Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents (e.g., residents who have fever, for example, due to a non-COVID-19 illness could be put at risk if moved to a COVID-19 unit). If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit. Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for [DIAGNOSES REDACTED]-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit). Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room. (Accessed on 06/08/20 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html) 2. A list of COVID-19 positive residents provided by the facility on 04/20/20, indicated both Residents #7 and #10 had tested positive for COVID-19. Resident #7 was noted to be symptomatic starting 04/03/20, was sent out to hospital on [DATE] and tested positive on 04/07/20. Resident #10 was noted to be asymptomatic but tested positive on 04/08/20. Review of Resident #7's respiratory assessments (which monitored temperature, pulse, respirations, blood pressure, oxygen saturation, right/left lung sounds and any change in respiratory status) revealed an assessment was not conducted on 03/29/20 or 04/02/20. Review of Resident #7's nursing progress note dated 04/04/20 indicated Resident #7 had been sent out to the hospital. It reflected, Resident remains hospitalized at this time. Received a call from the family member (the RP), checking on her brother, this nurse told her that her brother was sent out to the hospital last night due to elevated temp. Sister got upset demanding and asking more questions, the nurses on duty apologized to her, and she states that's ok but that's unprofessional, further she will talk to somebody. Review of Resident #10's respiratory assessments revealed an assessment was not conducted on 04/18/20. Review of Resident #10's nursing progress note dated 04/17/20 at 2:10 PM revealed Resident #10's physician was called to give an update on his current status of [MEDICATION NAME] for pneumonia. His temperature was noted to be 100.1. Tylenol was given and the temperature came down to 98.1. The nurse indicated his oxygen saturation on room air was 89-91% and the resident was removing his O2 because he did not feel that he needed it. A new order received was received to discontinue [MEDICATION NAME] and start [MEDICATION NAME] 200 mg BID x 5 days and [MEDICATION NAME] 500 mg daily x 5 days for COVID-19 19. There was no evidence Resident #11 was monitored for potential respiratory issues the following day on 04/18/20. Review of Resident #1's Admission Record, dated 04/22/20, revealed he was [AGE] years old and was originally admitted to the facility on [DATE]. Review of Resident #1's Admission Record revealed his [DIAGNOSES REDACTED].#1's undated comprehensive care plan reflected .(Resident #1) is at risk for COVID-19 Respiratory Infection related to Age, DX (diagnosis), and/or Living Environment . Monitor for Signs/Symptoms of fever 100.4, subjective fever, chills, muscle aches, rhinorrhea, sore throat, cough, SOB (shortness of breath), nausea/vomiting, headache, abdominal pain and diarrhea . Notify MD (medical doctor) of any abnormal findings . Review of Resident #1's Respiratory Evaluations revealed there were no vital signs or lung sounds documented for 04/18/20. Review of Resident #3's Admission Record, dated 04/23/20, revealed she was

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) [AGE] years old and was originally admitted to the facility on [DATE]. Review of Resident #3's Admission Record revealed her [DIAGNOSES REDACTED].#3's comprehensive care plan, created on 03/17/20 and revised on 04/22/20, reflected . The resident is at risk for COVID-19 Respiratory Infection related to Age, DX (diagnosis), and/or Living Environment. (Resident #3) is non-compliant at times with wearing s (sic) face mask . Monitor for Signs/Symptoms of fever 100.4, subjective fever, chills, muscle aches, rhinorrhea, sore throat, cough, SOB (shortness of breath), nausea/vomiting, headache, abdominal pain and diarrhea . Notify MD (medical doctor) of any abnormal findings . Review of Resident #3's Respiratory Evaluations revealed there were no vital signs or lung sounds documented for 04/18/20. Review of Resident #2's Admission Record, dated 05/17/20, revealed he was [AGE] years old and was originally admitted to the facility on [DATE]. Review of Resident #2's Admission Record revealed his [DIAGNOSES REDACTED]. Resident #2's undated comprehensive care plan reflected . (Resident #2) is at risk for COVID-19 Respiratory Infection related to Age, DX (diagnosis), and/or Living Environment. (Resident #2) is non-compliant at times with wearing s (sic) face mask Monitor for Signs/Symptoms of fever 100.4, subjective fever, chills, muscle aches, rhinorrhea, sore throat, cough, SOB (shortness of breath), nausea/vomiting, headache, abdominal pain and diarrhea . Notify MD (medical doctor) of any abnormal findings . Review of Resident #2's Respiratory Evaluations revealed there were no vital signs or lung sounds documented for 04/18/20. Review of Resident #4's Admission Record, dated 05/17/20, revealed she was [AGE] years old and was originally admitted to the facility on [DATE]. Review of Resident #4's Admission Record revealed her [DIAGNOSES REDACTED].#4's undated comprehensive care plan reflected . (Resident #4) is at risk for COVID-19 Respiratory Infection related to Age, DX (diagnosis), and/or Living Environment. (Resident #4) is non-compliant at times with wearing s (sic) face mask . Monitor for Signs/Symptoms of fever 100.4, subjective fever, chills, muscle aches, rhinorrhea, sore throat, cough, SOB (shortness of breath), nausea/vomiting, headache, abdominal pain and diarrhea . Notify MD (medical doctor) of any abnormal findings . Review of Resident #12's Admission Record, dated 04/22/20, revealed she was [AGE] years old and was originally admitted to the facility on [DATE]. Review of Resident #12's Admission Record revealed her [DIAGNOSES REDACTED]. Resident #12's comprehensive care plan, created on 03/17/20 and revised on 04/22/20, reflected . (Resident #12) is at risk for COVID-19 Respiratory Infection related to Age, DX (diagnosis), and/or Living Environment Monitor for Signs/Symptoms of fever 100.4, subjective fever, chills, muscle aches, rhinorrhea, sore throat, cough, SOB (shortness of breath), nausea/vomiting, headache, abdominal pain and diarrhea . Notify MD (medical doctor) of any abnormal findings . Review of Resident #12's Respiratory Evaluations revealed there were no vital signs or lung sounds documented for 04/15/20. Review of Resident #13's Admission Record, dated 04/22/20, revealed she was [AGE] years old and was originally admitted to the facility on [DATE]. Review of Resident #13's Admission Record revealed her [DIAGNOSES REDACTED]. Resident #13's comprehensive care plan, created on 03/17/20, reflected . (Resident #13) is at risk for COVID-19 Respiratory Infection related to Age, DX (diagnosis), and/or Living Environment Monitor for Signs/Symptoms of fever 100.4, subjective fever, chills, muscle aches, rhinorrhea, sore throat, cough, SOB (shortness of breath), nausea/vomiting, headache, abdominal pain and diarrhea . Notify MD (medical doctor) of any abnormal findings . Review of Resident #12's Respiratory Evaluations revealed there were no vital signs or lung sounds documented for 04/15/20 and 04/16/20. Review of Resident #14's Admission Record, dated 04/22/20, revealed she was [AGE] years old and was originally admitted to the facility on [DATE]. Review of Resident #14's Admission Record revealed her [DIAGNOSES REDACTED]. Resident #14's comprehensive care plan, created on 03/17/20, reflected . (Resident #14) is at risk for COVID-19 Respiratory Infection related to Age, DX (diagnosis), and/or Living Environment Monitor for Signs/Symptoms of fever 100.4, subjective fever, chills, muscle aches, rhinorrhea, sore throat, cough, SOB (shortness of breath), nausea/vomiting, headache, abdominal pain and diarrhea . Notify MD (medical doctor) of any abnormal findings . Review of Resident #14's Respiratory Evaluations revealed there were no vital signs or lung sounds documented for 04/15/20 or 04/16/20. Interview with LVN E on 04/21/20 at 4:30 PM revealed respiratory assessments for residents who were COVID-19 positive were supposed to be done once a shift by nurses only, totaling three times a day. Interview with the DON on 04/21/20 at 5:22 PM revealed respiratory assessments for COVID-19 positive residents should be done at least twice a day. She said herself and the regional consultant were monitoring to ensure they were completed. The DON said the day prior, she noticed there were some respiratory assessments missing on 04/18/20 and various other shifts and she was looking into it and tried to contact the nurses that worked on Halls A and B on all three shifts to see why the respiratory assessments were not completed. She said she had not been able to reach any of them. The DON was asked why it was important to complete the respiratory assessments on the COVID-19 positive residents. She responded, With any kind of virus, anyone can have a change of condition very quickly and we want to monitor to see if we need to alert doctor to any change and need for special orders, etc. Review of the facility's COVID-19 Plan (undated) reflected, .If a resident or residents have or are suspected to have COVID-19 related to the respiratory assessment or identification of the criteria above (fever, cough, shortness of breath, close contact with a person known to have COVID-19), the following should be followed: .Increase respiratory assessments on all residents who reside on the hall(s)/Unit(s) to BID (twice a day). Review of the CDC's Responding to Coronavirus (COVID-19) in Nursing Homes revealed: Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections. Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms. (Accessed on 06/08/20 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html) 3. An interview with the Staffing Coordinator (SC) on 04/27/20 at 3:33 PM revealed that she was responsible for the CNA weekly schedule assignments. She said the ADON did schedules for nurses, but the DON had recently taken over. She said with the eight halls in the building, she had worked mostly on two halls on the second floor, including COVID-19 positive isolation Hall B, but had worked all over the building throughout the month of April 2020. She said agency staff were used to fill in the gaps when the CNAs had their days off. She said agency staff were assigned to COVID-19 halls but she did not move them around on their shift. She said she did not know if the PRN agency staff worked at other facilities. An interview with LVN H on 04/27/20 at 4:20 PM revealed she was a PRN nurse from an agency. She said she was on one hall this shift, Hall A (a COVID-19 isolation hall) last week and a different hall yesterday. She said she found out her daily schedule when she arrived to work. When asked if she was told she had to be dedicated staff on the COVID-19 hall if she worked it, she replied no. An interview with CNA I on 04/27/20 at 4:27 PM revealed she was PRN agency staff. She said she had worked two of the three COVID-19 positive isolation halls and the night prior she worked a double shift on a non-COVID-19 hall. She said in total for April 2020, she had worked on four different halls and was not dedicated to one. An interview with the DON on 04/27/20 at 5:06 PM revealed she and the ADON were in charge of nurse staffing. She said, We try the best we can to dedicate staff, but we have to use the resources we can. We have a designated person for that day, but they may work a different hall the next day. She said no PRN or agency staff were dedicated to the COVID-19 positive isolation halls. She said they review staffing daily to ensure staff stay on the same hall if they are working a double shift, but the next day the staff may work a different halls as long as they are wearing appropriate PPE and performing hand hygiene. She stated staff may work an isolation hall one day and then a non-isolation hall the next day. She said she tried to keep staffing as consistent as possible, but unfortunately it didn't always happen. The DON said staff were allowed to work at other (Corporate company name) facilities. She said the agency staff were fully aware of that policy. She said the agency management kept track of what agency staff were working multiple nursing homes and tracking which of those homes had COVID-19 outbreaks. She said the facility did not track it. She said there were two other buildings in the county that he knew of that were sister facilities the agency staff were allowed to work at. An interview with the ADM on 04/27/20 at 6:02 PM revealed the facility tried as best they could to keep staff on the same assignment/unit. He said there was no one at the facility who was tracking where the agency staff were working, if they were working at other facilities or if they had been exposed. He said it was up to the agency. He said the actual agency that assigned staff knew the facility had COVID-19 positive residents so they were keeping track of the agency staff that worked there and were supposed to inform them that they could not work anywhere else unless it was COVID-19 positive facilities. The ADM stated they were not tracking agency staff because they were not facility employee and he didn't know how they would track them outside the facility. He said the agency staff could work at two of the facility's sister facilities that had positive COVID-19 cases. The ADM stated once agency staff worked at the facility they were considered exposed and they could work wherever they were needed at the facility. Review of the facility's COVID Action Plan revision date 04/17/2020 reflected, .If the resident meets the criteria of Confirmed/Presumed COVID: .If a resident meets the criteria of Confirmed/Presumed COVID: The resident will have a mask placed immediately and moved to designated isolation room; .The facility will follow the direction of the Local Health Department; .Implement active screening of residents and staff for fever and respiratory symptoms; . The nurse will contact the physician immediately and the designated isolation care team will take over the care of the resident on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455653	A. BUILDING _____ B. WING _____	**05/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SKYLINE NURSING CENTER	**3326 BURGOYNE DALLAS, TX 75233**

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 -** Many	(continued... from page 4) isolation; . Staff will be re-educated on the isolation process and that only designated staff will care for the isolated residents that have presumed and/or active COVID . Review of the CDC's Responding to Coronavirus (COVID-19) in Nursing Homes revealed: Ideally the unit should be physically separated from other rooms or units housing residents without confirmed COVID-19. ?Depending on facility capacity (e.g., staffing, supplies) to care for affected residents, the COVID-19 care unit could be a separate floor, wing, or cluster of rooms. Assign dedicated HCP to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. HCP working on the COVID-19 care unit should ideally have a restroom, break room, and work area that are separate from HCP working in other areas of the facility. ?To the extent possible, restrict access of ancillary personnel (e.g., dietary) to the unit. (Accessed on 06/08/20 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html) 4. Review of the facility's COVID-19 roster, revealed the following residents residing on the secured unit tested positive for COVID-19: -Resident #16 tested positive on 04/21/20 for COVID-19. -Resident #17 tested positive on 04/24/20 for COVID-19. -Resident #18 tested positive on 04/24/20 for COVID-19. -Resident #19 tested positive on 04/24/20 for COVID-19. -Resident #20 tested positive on 04/24/20 for COVID-19. Review of Resident #16's quarterly MDS assessment dated [DATE] revealed he was a [AGE] year old male who admitted to the facility on [DATE]. His active [DIAGNOSES REDACTED]. Resident #16's MDS assessment indicated he had severe cognitive impairment. He had no behaviors ([MEDICAL CONDITION], rejection of care and wandering). He used a wheelchair for mobility and required staff physical assistance for his ADLs. Review of Resident #16's care plan (undated) revealed, He has tested positive for COVID-19 Respiratory Infection Infectious Disease. Strong suspicion that COVID-19 was contracted by going into the community for [MEDICAL TREATMENT]. Intervention included for the resident to wear a mask when staff was present in room, follow contact and droplet isolation precautions as per policy, frequent vitals monitoring, [MEDICATION NAME] therapy as ordered, in room activities and hand washing throughout the day. Review of Resident #16's April 2020 nursing notes revealed he was sent to the hospital on [DATE] for an elevated temperature. He tested positive for COVID-19 while at the hospital and the facility was notified on 04/21/20. He readmitted to the facility on [DATE] into the secured unit. He was noted to be in isolation in his room on the secured unit. Review of Resident #17's quarterly MDS assessment dated [DATE] revealed he was [AGE] year old male admitted to the facility on [DATE]. His active [DIAGNOSES REDACTED]. He had severe cognitive impairment, inattention and disorganized thinking. His behavior included delusion, but no wandering or rejection of care. Resident #17 was independently ambulatory and required staff assistance for ADLs. Review of Resident #17's care plan (undated) revealed, The resident has tested positive for COVID-19 Respiratory Infection Infectious Disease. His care plan also indicated he was non-compliant in wearing a face mask and with social distancing. Interventions were to encourage the resident to wear a mask when staff was present in the room, follow contact and droplet isolation precautions as per policy, follow isolation meal precautions per policy, frequent vital sign monitoring, resident to be masked if demonstrating wandering behaviors and will not redirect back to isolation and staff to encourage resident to wash hands multiple times throughout the day. Review of Resident #17's nursing note dated 04/26/20 reflected, This resident is positive for COVID-19 and on isolation which he maintains occasionally. Review of Resident #18's quarterly MDS assessment dated [DATE] revealed he was an [AGE] year-old male admitted to the facility on [DATE]. He had moderate cognitive impairment, no behaviors (including rejection or wandering). He required staff assistance for his ADLs and used a wheelchair for mobility. His active [DIAGNOSES REDACTED]. Review of Resident #18's care plan (undated) revealed, The resident has tested positive for COVID-19 Respiratory Infection Infectious Disease. It also indicated he had a communication problem, hearing deficit and a history of kissing on female staff and was non-compliant at times with wearing a face mask. Interventions were to encourage the resident to wear a mask when staff was present in the room, follow contact and droplet isolation precautions as per policy, follow isolation meal precautions per policy, frequent vital sign monitoring, the resident was to be masked if demonstrating wandering behaviors and would not redirect back to isolation and staff to encourage the resident to wash hands multiple times throughout the day. Review of Resident #18's nursing notes dated 04/26/20 indicated that the resident was COVID-19 positive and on droplet/contact isolation. It reflected, Resident is not complaint with mask and would not stay in his room. He was redirected several times, still came out of his room. Will continue to redirect and maintain distance from other residents. Review of Resident #19's admission MDS assessment dated [DATE] revealed that he was a [AGE] year old male admitted to the facility on [DATE]. His active [DIAGNOSES REDACTED]. He had severe cognitive impairment, inattention and disorganized thinking. His behaviors included behavioral symptoms (not directed towards others), rejection of care daily and wandering that significantly intruded on the privacy of others. He required staff assistance with all ADLs and used a wheelchair for mobility. Review of Resident #19's care plan (undated) revealed, The resident has tested positive for COVID-19 Respiratory Infectious Disease. He was also at risk for choking due to eating inedible food or things such as papers, plastics and trash. It also noted he was non-complaint at times with wearing a face mask. Interventions were to encourage the resident to wear a mask when staff was present in the room, follow contact and droplet isolation precautions as per policy, follow isolation meal precautions per policy, frequent vital sign monitoring, the resident was to be masked if demonstrating wandering behaviors and will not redirect back to isolation and staff to encourage resident to wash hands multiple times throughout the day. Review of Resident #19's nursing note dated 04/26/20 reflected, Resident grabbing other residents' food. He was redirected, res became combative during redirection. He dodges redirection and rushe