STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235077	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HALLMARK LIVING HOLLAND	493 W 32ND ST HOLLAND, MI 49423

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 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement a thorough, effective assessment process to detect a change in condition and prevent the spread of a respiratory infection for 7 of 7 residents (Residents #1, #2, #3, #4, #5, #6 and #7) reviewed for COVID-19 signs and symptoms. The deficient practice resulted in an immediate jeopardy when Resident #5 was admitted with signs and symptoms of COVID-19 went unassessed and monitored, required CPR (Cardiopulmonary Resuscitation), and required an immediate transfer to the Emergency Department. The facility also failed to monitor Residents #1, #2, #3, #4, #6 and #7's vital signs and symptoms to detect a change in condition. This deficient practice placed all facility residents and staff at risk for developing COVID-19, resulting in the potential for serious harm, injury, and/or death. Findings include: Review of a Face Sheet revealed Resident #5 is a [AGE] year-old female admitted [DATE] with pertinent [DIAGNOSES REDACTED]. Review of the National Institutes of Health website: Clinical Methods: The History, Physical, and Laboratory Examinations. 3rd edition. Walker HK, Hall WD, Hurst JW, editors, Boston: Butterworths; 1990. Normal body temperature is considered to be 37C (98.6F); however, a wide variation is seen. Among normal individuals, mean daily temperature can differ by 0.5C (0.9F), and daily variations can be as much as 0.25 to 0.5C. The nadir (lowest) in body temperature usually occurs at about 4 a.m. and the peak at about 6 p.m. .Normal rectal temperature is typically 0.27 to 0.38C (0.5 to 0.7F) greater than oral temperature. Axillary temperature is about 0.55C (1.0F) less than the oral temperature. (https://www.ncbi.nlm.nih.gov/books/NBK331/). Review of a COVID-19 Admission Assessment Algorithm revised [DATE], provided by the facility revealed: CATEGORY 3: Respiratory Symptoms attributed to another cause WITHOUT testing. Admit to quarantine room- may cohort. All facilities may accept IF: At least 7 days after onset of symptoms AND no fever x (times) 72 hrs (hours) without fever reducing meds NEED DATE OF LAST FEVER (minimum of 7 days from onset- may be longer if not fever free x72 hrs). Monitor EVERY SHIFT for development of symptoms x 14 days CONTACT PRECAUTIONS. . (sic) Review of a facsimile from the Long Term Acute Care (LTAC) Facility sent to the nursing home on [DATE], with the health history for Resident #5, revealed on [DATE], one gram/100 milliliters of Calcium [MEDICATION NAME] is to be administered via intravenously every 8 hours with a discontinuation date of [DATE]. . Labs drawn on [DATE] indicated Resident #5 had a critical calcium level of 6.1 mg/dl (milligrams per deciliter). The previous lab revealed on [DATE] Resident #5 had a critical calcium lab of 5.7 mg/dL. On ,[DATE] Resident #5 had sputum culture that was positive for MSSA ([MEDICAL CONDITION]-susceptible Staphylococcus Aureus). . Recent positive sputum for [MEDICAL CONDITION]-susceptible Staphylococcus aureus colonization verses true pneumonia. However, the patient has been adequately treated with antibiotics. . Chest x-ray looks more like congestive changes than pneumonia. . Chest X-ray on [DATE] impression: Continued atelectasis/infiltrate at the left base with pleural effusion. On [DATE] temperatures recorded were 99.0 axillary at 8:40 a.m. and 4:45 p.m., and 99.8 axillary at 12:00 a.m., calcium recorded as low. . on [DATE] Resident #5 had several axillary temperatures ranging from 101.9 to 102.2. On [DATE] Resident #5 had an axillary temperature of 100.7. Review of Resident #5's health records sent with Resident #5 to the nursing home from the Long Term Acute Care Facility upon admission via transportation company on [DATE] revealed on [DATE], Resident #5 had [DIAGNOSES REDACTED]. Resident #5 had intermittent fevers since [DATE] and was on a ventilator. On [DATE] a [MEDICAL CONDITION] and Critical care progress note revealed the resident had acute hypoxemic (lack of oxygen) and hypercarbic (carbon [MEDICATION NAME] retention) [MEDICAL CONDITION] with recent multiple re-intubations (now with trach) . in guarded condition .[MEDICATION NAME] by aerosol every 6 hours as needed . Resident #5 had several axillary temperatures on [DATE] that ranged from 100.6 to 103 degrees Fahrenheit. Orders for 1 gram of Calcium [MEDICATION NAME] intravenously dated [DATE] every 12 hours for four doses. Orders on [DATE] revealed to increase to 2 Tums (a calcium supplement) three times a day and 1-gram Calcium chloride intravenously. On [DATE] Resident #5 had an axillary temperature of 100.7 at 8:00 a.m. and a low potassium of 3.1 done on [DATE]. The potassium was redrawn on [DATE] and was 3.5. The discharge medication list sent to the facility with a run date of [DATE] at the top of the page revealed orders for Calcium [MEDICATION NAME] Antacid 500 mg to start on [DATE] and end [DATE], 1 GM (gram) calcium [MEDICATION NAME] intravenously (IV) to start [DATE] and end [DATE], 1 GM Calcium [MEDICATION NAME] IV to start [DATE] and end [DATE]. [MEDICATION NAME] (blood pressure medication) 1 milligram (mg) at bedtime start [DATE] and end [DATE] [MEDICATION NAME]-[MEDICATION NAME] (inhaler) 3 ML (milliliters) every 6 hours as needed, start date [DATE]. [MEDICATION NAME] (blood pressure medication) 25 mg every hour starts [DATE]. [MEDICATION NAME] (blood pressure medication) 50 mg tablet every 8 hours start [DATE]. [MEDICATION NAME] (a diuretic) tablet 40 mg every morning started [DATE]. No current labs reflecting the calcium levels of Resident #5 prior to discharge and post infusion of calcium [MEDICATION NAME] intravenously and no documentation was provided for Resident #5's COVID-19 status. In an interview on [DATE] at 10:25 a.m., the Hospitality Aide (HA) G reported she started working at the facility about a week ago and assisted with vital signs and other tasks on the floor. In an interview on [DATE] at approximately 11:00 a.m., the Nursing Home Administrator reported Resident #5 tested negative for COVID-19 upon admission to the facility and was placed in the TCU unit where new admissions are placed for 14 days on transmission-based precautions. Resident #5 transferred to the hospital the day after admission and tested positive for COVID-19. The NHA reported no staff or residents had COVID-19 at this time. The NHA reported residents were required to have two negative COVID-19 tests before admission to the facility. In an interview on [DATE] at approximately 1:20 p.m., Admissions Coordinator (AC) A reported that the Long Term Acute Care Facility on the east side of the state that Resident #5 came from had no positive cases of COVID-19 and did not meet any criteria for screening for COVID-19 prior to the residents arrival to their facility even though she is [AGE] years old, with a [MEDICAL CONDITION] and previously on a ventilator, and from a region of the state that had a high prevalence of COVID-19. In an interview on [DATE] at 1:40 p.m., the Nursing Home Administrator (NHA) reported all the staff trained to screen residents for COVID-19 and can communicate their findings to the nurses. The staff have an education book at the employee entrance. The NHA reported they verbally educated staff on the floors and did not have any sign in sheets that indicated staff had received the education. In an interview on [DATE] at 3:02 p.m. Certified Nursing Assistant (CNA) N reported there was a [MEDICAL TREATMENT] resident on the TCU side of the facility and when that resident went out to [MEDICAL TREATMENT], she exited and returned through the door on the TCU side of the building. CNA N reported that over the weekend the COVID -19 screening for residents was every 4 hours but not sure what it was this day. During an observation, interview and record review on [DATE] at 3:10 p.m., several screening sheets for the residents in the facility are spread out on the desk at the TCU unit nurses station, and some on the clipboard in no particular order revealed no dates or times on all the pages, different formats for recording the screenings, and some screenings written on blank pieces of paper. Some of the forms had blank spaces. Registered Nurse (RN) O reported the CNA's just needed to put the vital signs on a piece of paper and then they put them into the computer. RN O reported the Hospitality Aide collected the vital signs on the residents this

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235077	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HALLMARK LIVING HOLLAND	493 W 32ND ST HOLLAND, MI 49423

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 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) morning. There were no signatures on the forms indicating licensed personnel reviewed the vital signs collected. When queried about the training of the Hospitality Aide to collect vital signs on the residents, Licensed Practical Nurse (LPN) L reported she personally trained the Hospitality Aide to do vital signs on the residents and provided a Certificate of Completion form dated [DATE] with Hospitality Aide (HA) G's name on it. In an interview on [DATE] at 3:37 p.m., The NHA reported that staff screened residents for COVID-19 symptoms three times a day and then the Corporate Clinical staff reviewed them. At this time, the NHA flipped through the forms and acknowledged they were not in any order. The Director of Nursing (DON) reported the residents were to have a screening for COVID-19 once a shift and staff needed to put the information on a piece of paper and then chart them in the computer. The DON reported the staff do not consistently chart their findings in the computer. The DON also reported that there was no formal education provided to the staff. In an interview on [DATE] at 9:14 a.m., Admissions Coordinator (AC) A reported that even though Resident #5 came from the east side of the state where COVID-19 was prevalent, she talked to the discharge coordinator at the Long Term Acute Care (LTAC) Facility and infections were of no concern for this resident. AC A reported the LTAC faxed over the health history and she sent it to the DON, the NHA, and the Regional Consultant to review. AC A reported the LTAC Facility told her there were no COVID-19 cases at their facility. When queried about the physicians' input on admissions to the facility, AC A reported the physician did not review information about the residents prior to their arrival and after the resident arrived to the facility, they will see them. AC A reported the discharging facility will send orders which is a list of medications the resident is on at the LTAC for admission to the nursing facility. Once the resident arrives to the facility, the physician will review and confirm the orders. AC A reported there was no indication that Resident #5 had COVID-19 prior to her arrival on [DATE] and did not know she had COVID-19 until she went to the hospital the next day on [DATE]. AC A reported there were no concerns with the admission of Resident #5 to the facility other than she is a [AGE] year-old person with a [MEDICAL CONDITION]. In an interview on [DATE] at approximately 11:00 a.m., the Nursing Home Administrator (NHA) reported Resident #5 admitted to the facility on [DATE] and was negative for COVID-19. On [DATE] resident #5 had a [MEDICAL CONDITION] and then sent to the hospital. At the hospital, the resident tested positive for COVID-19. NHA reported new admissions who tested positive in the past needed 2 negative tests prior to admission. In an interview on [DATE] at 11:36 a.m., Nurse Practitioner (NP) V reported she gave verbal orders on [DATE] for Resident #5 when she admitted to the facility. NP V reported she saw Resident #5 on [DATE] to do her initial assessment when an hour later Resident #5 had a [MEDICAL CONDITION] and started CPR (cardiopulmonary resuscitation), then sent to the hospital. NP V reported she did not know the COVID-19 status of the resident. NP V reported she did review a faxed health history of Resident #5 from the Long-Term Care Facility (LTAC) prior to the arrival of Resident #5 and noticed she had pneumonia. The second set of Resident #5's health history arrived when the resident arrived at the facility. NP V reported new admissions should have a screening for COVID-19 prior to their arrival to a nursing home and did not know Resident #5 had COVID-19 until after she went to the hospital on [DATE]. In an interview on [DATE] at 3:47 p.m., Licensed Practical Nurse/Unit Manager (LPN) L reported she worked on [DATE] and assisted with the admission of Resident #5 by setting up the PEG tube feeding. LPN L reported that LPN J was assigned to Resident #5 and was the admitting nurse. LPN L reported the Director of Nursing (DON) came Resident #5's room to set up the [MEDICAL CONDITION] connection and supplies for Resident #5 and Certified Nursing Assistant (CNA) W assisted with admission process as well by obtaining vital signs and reviewing the admission check list. LPN L reported she reviewed the medication List with Nurse Practitioner (NP) V and clarified the admission orders [REDACTED]. The LTAC told LPN L that Resident #5 only needed the intravenous calcium [MEDICATION NAME] while she was at the LTAC and that it could be discontinued at the nursing home. LPN L reported she put the orders for Resident #5 in the computer that day Resident #5 admitted to their facility and went by the medication list sent previously (clarified [DATE]) and updated the list once the resident arrived at the facility with new paperwork. LPN L reported she put the medications into the electronic medical record and did not know why some medications and treatments were not charted on [DATE], and explained that the time the orders were put into the computer were past the time the medication was due. In an interview on [DATE] at 1:51 p.m., Certified Nursing Assistant (CNA) R reported when Resident #5 arrived at the facility on [DATE], he obtained the vital signs for Resident #5 and gave them to the nurse and did not recall the resident having an elevated temperature. He also did a checklist of inventory for her. The DON came in the room and did a skin assessment and assisted with her transfer to the bed. CNA R reported that the last time he worked he was checking the residents' vital signs twice a shift after they learned Resident #5 was confirmed positive for COVID-19 after she discharged to the hospital. CNA R reported there is no set time to do resident screenings if it is done during their shift. There are no specific forms to use for the screenings. Sometimes staff write the screenings on a blank piece of paper. CNA R reported that he knows how to look for signs and symptoms of a cough or sore throat but does not recall any education by the facility for signs and symptoms to look for. In an interview on [DATE] at 3:16 p.m., Licensed Practical Nurse (LPN) J reported she was the floor nurse the day Resident #5 admitted to the facility, but LPN/Unit Manager L did the admission for Resident #5 so LPN J could attend to the other residents on the unit. LPN J reported she checked Resident #5's blood sugar during her shift and at that time she checked her [MEDICAL CONDITION] and PEG (Percutaneous endoscopic gastrostomy) tube. LPN J reported there were 2 admissions on [DATE] and the Director of Nursing (DON) did one admission and LPN L did Resident #5. LPN J clarified that meant LPN L did everything from getting orders and completed all admission assessments and did not have any indications that Resident #5 had any infections. LPN J reported that the Certified Nursing Assistants (CNA's) get the temperatures of the residents and their oxygen saturations and if they notice the resident was breathing abnormally, especially the ones who cannot verbalize concerns, the CNA's report their findings to the nurse. During an observation and an interview on [DATE] at approximately 3:25 p.m., Certified Nursing Assistant (CNA) I reported she is not sure if the COVID-19 screenings for the residents were done on this day because her shift started about 10:00 a.m. and could not find the screening sheets. CNA I reported she did not receive that information during the shift report when she came on shift. LPN J could not find the record for resident screenings for COVID-19 and reported staff did the screenings. LPN J reported once the screening was complete, the nurse reviewed them, then the Director of Nursing (DON). The clipboard at the nurses' station had different forms with resident daily screenings of temperatures and oxygen saturations in a disorganized manner. There were missing days of screenings and some residents were missing screenings. CNA I could not find the screening for this day or confirm if the vital signs on the clip board entered the computer. Review of a Hospital Medical Record for Resident #5 revealed: Patient was recently transferred to nursing home here. Staff there noted that she did have a fever today. Developed pink frothy sputum. .Most Recent Vitals: Temperature Core 39.1 Deg C (degrees Celsius) (102.3 degrees Fahrenheit) Critical . [MEDICAL CONDITION] was placed with pink frothy sputum. Lungs are coarse throughout. . Patient apparently has not been ruled out for COVID . Assessment/Plan: Acute exacerbation of chronic hypoxic [MEDICAL CONDITION], probably secondary to healthcare associated pneumonia, patient with subacute [MEDICAL CONDITION], patient placed on ventilator, probable healthcare associated pneumonia, rule out COVID 19 . [DIAGNOSES REDACTED] critical, . [DIAGNOSES REDACTED] supplement per protocol, . probable septic shock . COVID 19 confirmed positive, . patient is having loose stools with [DIAGNOSES REDACTED]icile ([MEDICAL CONDITION]) positivity, . elevated troponin, probably secondary to demand ischemia, patient placed on ventilator, . urine positive for ESBL (Extended-Spectrum Beta-lactamase, a bacteria). Resident #1 According to Resident #1's face sheet dated [DATE] she was a [AGE] year-old female admitted to the facility on [DATE] and had [DIAGNOSES REDACTED].\disease ([MEDICAL CONDITION]), cognitive communication deficit and cervical spinal cord injury at C2, surgical aftercare following surgery on the nervous system (onset [DATE]). Review of Resident #1's vital signs record revealed she had elevated temperatures on [DATE] at 1:06 AM (99.5 degrees Fahrenheit (F)), [DATE] at 3:31 AM (99.5 F), [DATE] at 6:25 AM (99.1 F), [DATE] at 7:28 PM (98.7 F) and [DATE] at 9:59 PM (97.9 F). According to Resident #1's progress note dated [DATE] at 2:26, Resident #1 was assessed. The note revealed her last temperature was taken on [DATE] at 9:59 PM (more than 4 hours prior to this assessment), her last pulse was taken on [DATE] at 1:40 AM (more than 24 hours prior to this assessment, her last blood pressure was taken on [DATE] at 1:40 AM (more than 24 hours prior to this assessment), and her last pulse was taken on [DATE] at 1:40 AM (more than 24 prior to this assessment. Resident #2 According to Resident #2's face sheet dated [DATE] she was a [AGE] year-old female last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. Review of Resident #2's progress notes dated [DATE] to [DATE] revealed no full lung assessments. Review of Resident #2's vital signs record [DATE] to [DATE] revealed her respirations were only assessed twice ([DATE] and [DATE]). There was no indication that her lung sounds were assessed from [DATE] to [DATE]. Resident #31 ` According to Resident #3's face sheet dated [DATE] was a [AGE] year-old male last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. Review of Resident #3 vital signs record from [DATE] to [DATE] revealed his oxygen saturation was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235077	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HALLMARK LIVING HOLLAND	493 W 32ND ST HOLLAND, MI 49423

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 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) 88% (percent) or below 10 times while on room air. The record indicated he was provided oxygen on [DATE]. There was no indication oxygen had been provided despite oxygen saturation measurements of 88% or below starting on [DATE]. Review of Resident #3 progress notes from [DATE] to [DATE] revealed one lung assessment had been completed by the Resident #3's practitioner on [DATE] and documented he had decreased lower lung fields, productive cough, no fever, pulse oxygen was 90% on 6 liters of oxygen provided through a nasal cannula. This did not match the information in the vital signs record as there was no indication he was on oxygen. Another assessment was completed on [DATE] at 9:58 AM (this did indicate oxygen was on but not how many liters it was set at) and did not match the vital signs record which indicated he was on room air. The next assessment was dated [DATE] at 3:37 PM but used old vital signs pulse on [DATE] at 9:57 am, respirations on [DATE] at 9:57 AM, blood pressure on [DATE] at 2:32 AM, Oxygen on [DATE] at 12:12 PM (on room air), and no indication that lung sounds were assessed. The progress notes on [DATE] was the last note at an attempt to do a lung assessment. Resident #6 According to Resident #6's face sheet dated [DATE] he was an [AGE] year-old male admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. Resident #6 was not his own responsible party. Review of Resident #6's progress notes from [DATE] to [DATE] revealed he had only one lung assessment documented the day of admission [DATE] at 10:34 PM. Resident #7 According to Resident #7's face sheet dated [DATE] she was a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was her own responsible party. Record review revealed no respiratory screens for the first 48 hours. Review of the progress note dated [DATE] at 2:45 AM revealed old vital signs were documented in this assessment. Pulse, blood pressure and respirations were dated [DATE] at 7:11 PM. Resident #4 Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE] revealed Resident #4 admitted to the facility on [DATE]. Brief Interview for Mental Status (BIMS), reflected a score of 9 out of 15 which represented Resident #4 had moderate cognitive impairment. Record review of the electronic health record temperature log from [DATE] - [DATE] reflected no temperatures recorded for ,[DATE], ,[DATE], and ,[DATE]. Record review of the electronic health record oxygen saturation log from [DATE] - [DATE] reflected no oxygen saturation recorded for ,[DATE], ,[DATE] - [DATE]. Record review of the progress notes from [DATE] - [DATE] indicated that the resident refused or declined to have his temperature or oxygen saturation taken. During a telephone interview on [DATE] at 10:22 AM, the NHA stated that Resident #4 left the building on an independent leave of absence to smoke cigarettes just off the facility property, a few times a day. According to the self-sign log, Resident #4 was gone anywhere from 30 to 90 minutes at a time. During a telephone interview on [DATE] at 3:08 PM, the NHA stated that the facility did not have a plan to actively admit COVID-19 positive residents and the facility would refer those admissions to their sister facility for admission. When asked if the facility was able to locate the COVID-19 testing done for Resident #5 prior to the admission on [DATE], the NHA stated, No. The NHA stated that Resident #5 did not have signs and symptoms of COVID-19 and therefore was not tested prior to admission. According to the documents received from the sending facility, Resident #5 did in fact exhibit signs and symptoms of COVID-19 prior to transfer including a fever on the day of the transfer. The NHA stated, Going forward we will definitely ask them (the sending facility) to test first. During a telephone interview on [DATE] at 1:15 PM, when asked about monitoring residents daily for COVID-19 signs and symptoms, the DON stated temperature and oxygen saturation were taken on all residents daily. The DON stated the staff charted the results in the electronic health record. When asked about the procedure for new admission assessments and vital signs, the DON stated that he expected an complete admission assessment to be documented with all new admissions and to obtain a complete set of vital signs 3 times daily on all new admissions. When asked if staff did respiratory assessments or other types of skilled daily assessments if a complete set of vital signs should be part of the assessment, the DON stated, Yes. When told that the vital signs that were part of assessments were up to 7 days old, the DON stated that he was unaware that was happening. The DON was unable to locate an admission assessment for Resident #5 before the exit of this survey. The DON stated, There is no admission assessment and no excuse for it. The DON stated that he did not know why the vital signs were not recorded in the electronic medical record for Resident #5. The facility was notified of Immediate Jeopardy (IJ) at F-684 on [DATE] at 3:40 PM and was identified on [DATE] and began on [DATE], due to the facility's failure to ensure complete and accurate assessments, necessary assessments, treatments and interventions to prevent the decline, resulting changes in resident conditions, and worsening of symptoms with the potential for serious injury and/or death for Resident #1, #2, #3, #4, #5, #6, and #7. This deficient practice placed all facility residents, at risk for serious harm, injury, and/or death. Immediacy was removed on [DATE] when the facility had the following in place for Residents: 1. Facility is adding COVID monitoring to MAR for completion by staff nurses as follows: COVID MONITORING: 2. Loss of smell, fatigue, GI upset, SOB, Cough, Decreased appetite. If the answer is YES they create a progress note right from the emar (electronic medical record) regarding the symptoms and physical assessment including vital signs. See attached 3. All change in condition will be notified to MD (medical doctor) immediately. 4. Facility will continue to complete temperature screening and pulse oximetry screening for all residents. Staff nurses are responsible to obtain, and this will be reviewed by IDT in morning meeting. DON/designee is responsible for this oversight. 5. Infection control screener UDA will be scheduled for every positive or PUI in the building. The Infection preventionist will initiate this process. See attached 6. Physician rounds will be performed with NP (Nurse Practitioner) and/or MD (medical director) the rounds will be completed three times per week with progress notes uploaded within 48 hrs. into the medical record. 7. Infection preventionist/designee will verify initiation of the Infection control screener on each resident with new symptoms within 24 hrs. 8. All licensed nurses will be in serviced on new respiratory infection screener for positive or active respiratory infections. They will also be in-serviced on basic screening for new symptoms via the MAR (Medication Administration Record) and notifying MD/NP of ALL condition changes immediately with a complete assessment of the patient including VS (vital signs). The Care path will be provided to all staff and education will be provided on talking points with the MD for all new and symptomatic patients. 9. Care path will be provided to all nursing staff at the nurse's station to review symptom management guidelines and physician talking points for all new and current Positive and PUI patients. Although the Immediate Jeopardy (IJ) was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity of Actual harm with potential for more than minimal harm that is not Immediate Jeopardy due to all staff had not been in-serviced on the corrective action implemented to remove the immediacy and sustained compliance has not been verified by the state agency.
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**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 implement a thorough, effective assessment process to screen all residents, staff and visitors daily for COVID-19 signs and symptoms, to monitor for changes in condition and prevent the spread of a respiratory infection through staff education and implementing effective infection control interventions for 7 of 7 residents (Residents #1, #2, #3, #4, #5, #6 and #7) reviewed for COVID-19 infection control. The deficient practice resulted in an immediate jeopardy when Resident #5 was admitted with signs and symptoms of COVID19 went unassessed and monitored, required CPR, and required an immediate transfer to the Emergency Department. Residents #1, #2, #3, #4, #6 and #7's vital signs and symptoms going unmonitored to detect a change in condition. Staff and visitors going unassessed and unmonitored. This deficient practice placed all facility residents, staff and visitors at risk for developing COVID-19, serious harm, injury, and/or death. Findings include: Review of a Face Sheet revealed Resident #5 is a [AGE] year-old female admitted [DATE] with pertinent [DIAGNOSES REDACTED]. Review of the National Institutes of Health website: Clinical Methods: The History, Physical, and Laboratory Examinations. 3rd edition. Walker HK, Hall WD,(NAME)JW, editors, Boston: Butterworths; 1990. Normal body temperature is considered to be 37C (98.6F); however, a wide variation is seen. Among normal individuals, mean daily temperature can differ by 0.5C (0.9F), and daily variations can be as much as 0.25 to 0.5C. The nadir in body temperature usually occurs at about 4 a.m. and the peak at about 6 p.m. . Normal rectal temperature is typically 0.27 to 0.38C (0.5 to 0.7F) greater than oral temperature. Axillary temperature is about 0.55C (1.0F) less than the oral temperature. (https://www.ncbi.nlm.nih.gov/books/NBK331/). Review of a health history report for Resident #5 provided to the facility from Long Term Acute Care Facility revealed that on [DATE] Resident #5 had several axillary temperatures ranging from 101.9 to 102.2. On [DATE] Resident #5 had an axillary temperature of 100.7. During an observation on [DATE] at 10:04 a.m., this surveyor pulled into the parking lot and observed a transportation van outside the TCU door entrance and the driver got out of van and approached the door to pick up a resident. This surveyor entered the building through the front lobby. In an interview on [DATE] at approximately 11:00 a.m., the Nursing Home Administrator (NHA) reported Resident #5 tested negative for COVID-19 upon admission to the facility and was placed in the TCU unit where new admissions are placed for 14 days on transmission-based precautions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235077	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HALLMARK LIVING HOLLAND	493 W 32ND ST HOLLAND, MI 49423

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 -** Few	(continued... from page 3) Resident #5 transferred to the hospital the day after admission and tested positive for COVID-19. The NHA reported no staff or residents had COVID-19 at this time. The NHA reported residents are required to have two negative COVID-19 tests before admission. During an observation on [DATE] at 12:03 p.m., a resident was using the phone at the CCU unit nurses' station that another resident had used earlier in the day. No cleansing of the phone between residents was observed. A male resident observed earlier leaving the facility by walking out the door on the CCU unit and came back entering the facility through the same door and no hand hygiene was noted. During an observation and an interview on [DATE] at approximately 12:15 p.m., the Hospitality Aide (HA) G brought a lunch tray from a resident's room and placed it on the cart with other lunch trays still distributed out to the residents. HA G reported she did sit the tray down on the resident table in the room. A Certified Nursing Assistant (CAN) nearby told HA G that the next time the tray needed to go directly to the kitchen. In an interview on [DATE] at approximately 1:20 p.m., Admissions Coordinator (AC) A reported that the Long Term Acute Care Facility on the east side of the state that Resident #5 came from had no positive cases of COVID-19 and did not meet any criteria for screening for COVID-19 prior to the residents arrival to their facility even though she was 94-years-old, with a [MEDICAL CONDITION] and previously on a ventilator, and from a region of the state that had a high prevalence of COVID-19. In an interview and record review on [DATE] at 1:00 p.m., the Director of Nursing (DON) reported there were four entrances that staff and visitors entered the facility. The facility currently did not have personal visitors for residents visiting the facility. The TCU unit was for new admissions that were quarantined for 14 days after admission and the unit where residents were picked up for services on that unit such as [MEDICAL TREATMENT] and general transfers. At this time a clip board with printouts from the Centers for Disease Control noted on a clipboard at the nurses station on the CCU unit and the DON reported staff were educated about COVID-19 through these handouts but did not have a sign in sheet to prove that staff read it and were educated. We then walked to the staff entry/break room where a table was set up with hand sanitizer, an oral thermometer, a temporal thermometer, a binder with the facility staff names on a sheet in alphabetical order. Upon review of the staff screening binder, there was 12 screening entries per page, per staff member to put the date, time, afebrile (without fever), asymptomatic (no symptoms), name and screener. The screening entry for Dietary Assistant (DA) Q revealed on [DATE] at 10:30, 67.3 written on the screener contact line, on [DATE] at 6:30 DA Q self-screened with 68.3 written on the screener contact line, on [DATE] DA Q self-screened with no temperature noted. On [DATE] DA Q signed in with no temperatures noted. On [DATE] DA Q signed in with no temperatures noted. Several more entries throughout the month of April for DA Q noted with temperatures, if recorded, ranging from 67.3 to 97.5. Several other staff screenings reviewed revealed incomplete or inaccurate data. When queried about the screening process, the DON reported that the staff screened themselves at the door and should be able to tell if they had a temperature or not and if they had a temperature over 100.5, then they should not come to work. The DON reported that since the Certified Nursing Assistants take vital signs of residents in the building, they were competent to do their own screening and another staff or nurse did not need to review or screen the staff reporting to work. When queried if he educated all staff on how to take temperatures for COVID-19 including non-clinical staff, the DON replied no and pointed to a binder on the employee entrance desk with several printouts about COVID-19 from the CDC (Center for Disease Control) website and no sign in sheet from employees acknowledging they had read it. This surveyor reviewed several more staff self-screenings that included their name and no symptoms or marked the box afebrile with no actual temperatures. The DON reported he did not look over the staff screening logs and reported he should probably start. In an interview on [DATE] at 1:40 p.m., the Nursing Home Administrator (NHA) reported all the staff trained to screen residents for COVID-19 and can communicate their findings to the nurses. The staff have an education book at the employee entrance. The NHA reported they verbally educated staff on the floors and did not have any sign in sheets that indicated staff had received the education. When queried about the facility entrances, the NHA reported that the residents who smoked and pertinent visitors can go out the CCU unit door, but no other visitors or staff can go through that door. Review of a sign in sheet on the desk near the CCU door entrance revealed from [DATE] to [DATE], several unidentified visitors entered through the CCU door including staff, not appropriately screened with temperatures ranging from 97.0 to 99.9 degrees Fahrenheit and no times of entry noted. The desk did not have a thermometer and a stand with hand sanitizer was in the foyer between the two doors to enter the facility. When queried about the sign in sheet, the NHA reported, Looks like we suck at it. During an observation and an interview on [DATE] at 2:47 p.m., Activity Assistant (AA) M opened the first door on the CCU unit, applied hand sanitizer from the stand, and then opened the second door to enter the facility and did not have a COVID-19 screening. AA M reported that employees and residents can enter through the CCU unit door but not visitors. AA M then proceeded to enter the Activity Room. In an interview on [DATE] at 3:02 p.m. Certified Nursing Assistant (CNA) N reported there was a [MEDICAL TREATMENT] resident on the TCU side of the facility and when that resident goes out to [MEDICAL TREATMENT], she exited and returned through the door on the TCU side of the building. CNA N reported that over the weekend the COVID -19 screening for residents was every 4 hours but was not sure what it was this day. During an observation, interview and record review on [DATE] at 3:10 p.m., several screening sheets for the residents in the facility are spread out on the desk at the TCU unit nurses station, and some on the clip board in no particular order revealed no dates or times on all the pages, different formats for recording the screenings, and some screenings written on blank pieces of paper. Some of the forms had blank spaces. Registered Nurse (RN) O reported the CNA's just needed to put the vital signs on a piece of paper and then they put them into the computer. RN O reported the Hospitality Aide collected the vital signs on the residents this morning. There were no signatures on the forms indicating licensed personnel reviewed the vital signs collected. When queried about the training of the Hospitality Aide to collect vital signs on the residents, Licensed Practical Nurse (LPN) L reported she personally trained the Hospitality Aide to do vital signs on the residents and provided a Certificate of Completion form dated [DATE] with Hospitality Aide (HA) G's name on it. In an interview on [DATE] at 3:37 p.m., the NHA reported that staff screened residents for COVID-19 symptoms three times a day and then the Corporate Clinical staff reviews them. At this time, the NHA flipped through the forms and acknowledged they were not in any order. The Director of Nursing (DON) reported the residents were to have a screening for COVID-19 once a shift and staff needed to put the information on a piece of paper and then chart them in the computer. The DON reported the staff did not consistently chart their findings in the computer. The DON also reported that there was no formal education provided to the staff. The DON reported when the residents who smoke exit the facility, they should perform hand hygiene when they return. The DON reported that all residents, including the residents who leave the facility to smoke are screened once a shift. In an interview on [DATE] at 9:14 a.m., Admissions Coordinator (AC) A reported that even though Resident #5 came from the east side of the state where COVID-19 was prevalent, she talked to the discharge coordinator at the Long Term Acute Care (LTAC) Facility and infections were of no concern for this resident. AC A reported the LTAC faxed over the health history and she sent it to the DON, NHA, and the Regional Consultant to review. AC A reported the LTAC Facility told her there were no COVID-19 cases at their facility. When queried about the physicians' input on admissions to the facility, AC A reported the physician did not review information about the residents prior to their arrival and after the resident arrive to the facility, they will see them. AC A reported the discharging facility will send orders which is a list of medications the resident is on at the LTAC for admission to admit them to the nursing facility. Once the resident arrives to the facility, the physician will review and confirm the orders. AC A reported there was no indication that Resident #5 had COVID-19 prior to her arrival on [DATE] and did not know she had COVID-19 until she went to the hospital the next day on [DATE]. In an interview on [DATE] at approximately 9:30 a.m., Registered Nurse (RN) B reported she read some of the education on the clip board but did not sign anywhere that she had read it because she was waiting for an in-service education for COVID-19. RN B reported she does not screen staff prior to them starting their shift and reported staff are not to come into the building if their temperature was 99 degrees Fahrenheit or above. RN B reported if someone had a temperature below the normal range it may be because they had a drink, or something could have altered their temperature. If that were to happen, RN B reported they should wait a few minutes and recheck their temperatures. In an interview on [DATE] at approximately 9:45 a.m., the facility Scheduler C reported that Therapy staff entered the facility through the door on the TCU unit because the therapy room was on that side. The therapy staff also do their own COVID-19 screening before their shift and she did not have a record of their screening. Scheduler C reported that transportations services come through the TCU unit door to pick up residents who transfer out and did not have a record of their screenings. She reported the TCU unit screened the visitors. In an interview on [DATE] at 10:25 a.m., the NHA reported that the Therapy staff have their own thermometer in their room and do their own screening. The reason they enter through the TCU unit entrance was because their room is over there and that way they did not have to walk through the whole building. In an interview on [DATE] at 11:36 a.m., Nurse Practitioner (NP) V reported new admissions should have a screening for COVID-19 prior to their arrival to a nursing home and did not know Resident #5 had COVID-19 until after she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235077	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HALLMARK LIVING HOLLAND	493 W 32ND ST HOLLAND, MI 49423

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 -** Few	(continued... from page 4) went to the hospital on [DATE]. During an observation on [DATE] at 2:40 p.m., this surveyor was redirected from the front lobby entrance to enter through the CCU entrance for new screening process. At this time, the Nurse Practitioner (NP) V entered the facility through the front lobby by the front office staff. When queried why this happened, the front office staff reported it was because she is the Nurse Practitioner. During an observation and an interview on [DATE] at 2:43 p.m., the Director of Nursing (DON) was at the CCU entrance and reported they were just now putting together the screening station at that entrance to screen staff and pertinent visitors. They were also going to start education for staff and confirmed that one staff member at the facility has COVID-19 and has been out of the facility for about one week. A few minutes later NP V re-entered the facility through the CCU entrance. In an interview on [DATE] at 3:16 p.m., Licensed Practical Nurse (LPN) J reported she was the floor nurse the day Resident #5 admitted to the facility, but LPN/Unit Manager L did the admission for Resident #5 so LPN J could attend to the other residents on the unit. LPN J reported she checked Resident #5's blood sugar during her shift and at that time she checked her [MEDICAL CONDITION] and PEG (Percutaneous endoscopic gastrostomy) tube. LPN J reported there were 2 admissions on [DATE] and the Director of Nursing (DON) did one admission and LPN L did Resident #5's. LPN J clarified that meant LPN L did everything from getting orders and completed all admission assessments and did not have any indications that Resident #5 had any infections. LPN J reported that the Certified Nursing Assistants (CNA's) get the temperatures of the residents and their oxygen saturations and if they notice the resident was breathing abnormally, especially the ones who cannot verbalize concerns, the CNA's report their findings to the nurse. During an observation and an interview on [DATE] at approximately 3:25 p.m., Certified Nursing Assistant (CNA) I reported she was not sure if the COVID-19 screenings for the residents were done on this day because her shift started about 10:00 a.m. and could not find the screening sheets. CNA I reported she did not receive that information during the shift report when she came on shift. LPN J could not find the record for resident screenings for COVID-19 and reported staff did the screenings. LPN J reported once the screening is complete, the nurse reviews them, then the Director of Nursing (DON). The clip board at the nurses' station had different forms with resident daily screenings of temperatures and oxygen saturations in a disorganized manner. There are missing days of screenings and some residents were missing screenings. CNA I could not find the screening for this day or confirm if the vital signs on the clip board entered the computer. During an observation and an interview on [DATE] at 4:00 p.m., LPN J reported the residents who smoked were able to go outside to smoke and exit through the TCU unit doors and are encouraged to wear a mask and use hand sanitizer when they come back to the facility. The staff are only screening the residents who leave the facility to smoke once a shift with the other residents. During an observation and an interview on [DATE] at 4:05 p.m., a food delivery truck was observed in the parking lot by the kitchen. When queried, the Maintenance Director D and the Director of Nursing (DON) reported the kitchen staff screened the visitors at the kitchen door, the delivery driver then brought the food into the kitchen and puts it directly into the cooler. The kitchen staff are then to bring the screening of the visitor to the front to put it with the rest of the screenings. Currently, there were a total of 5 points of entry for staff, residents and visitors to enter the facility without appropriate screening, assessments, and record keeping. The screening entry for the Rehabilitation Director (RD) P revealed on [DATE] at 8:10 temperature 94.5, no s/s (no signs and symptoms), no screener name or contact. Review of a Hospital Medical Record for Resident #5 revealed: Patient was recently transferred to nursing home here. Staff there noted that she did have a fever today. Developed pink frothy sputum. .Most Recent Vitals: Temperature Core 39.1 Deg C (degrees Celsius) (102.3 degrees Fahrenheit) Critical . [MEDICAL CONDITION] was placed with pink frothy sputum. Lungs are coarse throughout. . Patient apparently has not been ruled out for COVID . Assessment/Plan: Acute exacerbation of chronic hypoxic [MEDICAL CONDITION], probably secondary to healthcare associated pneumonia, patient with subacute [MEDICAL CONDITION], patient placed on ventilator, probable healthcare associated pneumonia, rule out COVID 19 . probable septic shock . COVID 19 confirmed positive, . patient is having loose stools with [DIAGNOSES REDACTED]licile ([MEDICAL CONDITION]) positivity, . elevated troponin, probably secondary to demand ischemia, patient placed on ventilator, . urine positive for ESBL (Extended-Spectrum Beta-lactamase). Review of the Centers for Disease Control (CDC) website: Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, last updated on [DATE] revealed: Key Concepts in This Guidance: Reduce facility risk: .limit points of entry and manage visitors, screen everyone entering the facility for COVID-19 symptoms, implement source control for everyone entering the facility, regardless of symptoms . Isolate symptomatic patients as soon as possible . Protect healthcare personnel. . Recommendations: 6. Manage visitor access and movement within the facility. .Limit points of entry to the facility and visitation hours to allow screening of all potential visitors. Actively assess all visitors for fever and COVID-19 symptoms upon entry to the facility. . 8. Monitor and manage healthcare personnel. Screen all HCP (healthcare providers) at the beginning of their shift for fever and symptoms consistent with COVID-19 . Fever is either measured temperature greater than or equal to 100.0 degrees Fahrenheit or subjective fever. Note that fever may be intermittent or may not be present in some individuals who are elderly, immunosuppressed Clinical judgement should be used to guide testing of individuals in such situations. . 9. Train and educate healthcare personnel. . 10. Implement environmental infection control.
.(https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html#manage_access)

During an interview on [DATE] at 11:19 AM, Nursing Home Administrator (NHA) revealed that their COVID-19 positive resident (Resident #5) came in on the 14th and coded (required cardiopulmonary resuscitation) on the 15th. She had a negative screening prior to entering our building. During an interview on [DATE] at 11:25 AM, the NHA revealed employees do their own screening they write an in and out temperature in the book. Then the DON or I will come in and check it once a day. Record review of the employee check in book was observed to be by last name, each page had 12 places that read, I have been screened upon entrance to work and provided place for the employee to fill out the following information: Date, Time, Afebrile (without fever), Asymptomatic, Name , Screener Name and Screener Contact. Review of the employee records found that most employees were writing their temps down on their paper twice a day. Review of Director of Nursing' (DON) check in form reflected that zero temperatures had been documented for 5 days for employees that worked between [DATE] - [DATE]. Review of the front office entrance Vendor Sign in Sheet and Questionnaire from ,[DATE] - [DATE] reflected that they failed to ensure/document temperatures for four of seventeen visitors including one surveyor that entered the facility. During the onsite investigation on [DATE], staff, residents and visitors were observed to be entering and exiting through four of the facility doors in the building. During an interview on [DATE] at 11:41 AM, Confidential Staff #1 (CS#1) P revealed the following, People have quit, I was not told by administration or was given not given any formal education on what to do since we had a positive COVID resident. Since [DATE], they have not given us, but I have asked for the company's policies and procedures. If there is a suspicion of a COVID positive resident, we were told we just wear a mask. (CS#1 P was observed pointing to her homemade mask). During an interview on [DATE] at 12:29 PM, Certified Nurse's Aide (CNA) Q revealed that she was the only aide on the unit and when she needed help she had to grab a Aide from a different unit for those residents that required 2 person care. CNA Q's mask was observed worn under her nose as droplet precaution signs were observed on every door across from the nurse's station and up and down the hall. Resident #8 was observed in his wheelchair exiting the CCU doors to go outside and smoke. CNA Q revealed that they had 2 residents from the CCU and one resident (R#4) from the 300 hall that frequently goes out the CCU doors to smoke. On [DATE] at 12:35 PM, Unit Manager (UM) L was observed coming out of an office off the CCU Nurses station without a mask on, went back in applied homemade mask prior to stepping out again. During an interview UM L revealed the following information about when Resident #5 and her code (need for cardiopulmonary resuscitation). They didn't give a special mask here for the code, we didn't know she (Resident #5) was positive until after the code. I was told she had a negative COVID test when she came into the building, now we are monitoring everyone for droplet precautions back here for the next 2 weeks/ During an interview on [DATE] at 1:20 PM, Certified Nurse's Aide (CNA) I revealed the following, We get report about what's going on with patients by previous staff, they (management) sometimes put handout's on a desk, no sit down and sign formal education meetings. During an employee break observation on [DATE] at 1:25 PM, in a small break room [ROOM NUMBER] small square tables were observed to be butted up together with both staff on their phones, no masks worn, facing each other less than 6 feet apart while a third employee was standing along the wall by the door. On [DATE] at 1:27 PM, CNA Q observed with mask worn below the nose while she walked down 300 Hall. On [DATE] at 1:35 PM, CNA Q was observed with her mask worn below her chin (nose and mouth exposed) during computer work at the nurses' station. During an interview on [DATE] at 1:46 PM, Resident #4 (R#4) was observed coming from outside and down the 300 Hall in a red bandana worn around his face. R#4 revealed, he was educated on the |

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235077	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HALLMARK LIVING HOLLAND	493 W 32ND ST HOLLAND, MI 49423

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 -** Few	(continued... from page 5) following when he goes out to smoke, Not to get close to people, stand like 6 to 12 feet away, wear my mask and wash hand and stuff. I wash my hands sometimes, not always. During an interview on [DATE] at 2:50 PM, Registered Nurse Unit Supervisor (RNUS) O revealed, No education as to what they (management) are doing with regards to COVID. The notes on the resident's doors (stating droplet precautions) were not put up until Friday afternoon. We were not given Personal Protective Equipment (PPE) to wear until Friday afternoon. RNUS O stated, Management did not tell us to take temperatures of [MEDICAL TREATMENT] patients prior to going out and coming back in. We do not take any temperatures of residents coming and going. RNUS O during the interview came across some papers and stated, Here was the education that was given out on ,[DATE] for staff to read and educate themselves. And no education has been provided on if this a dirty or clean unit it makes me feel terrible. One staff signature was noted on the ,[DATE] education from the nurses' station. On [DATE] at 3:00 PM, review of the [DATE] Education left in the TCU Nurses Station reflected only one employee signature. During an interview on [DATE] at 9:21 AM, CNA Q, stated that they were not educated on wearing masks, and revealed that, I have breathing problems as a reason for wearing her mask improperly. CNA Q revealed the following when asked if she was educated on the COVID positive resident, No, I didn't have any after what happened. Communication is very poor right now, whatever I hear is hearsay, it comes from so and so, it's really scattered. No hey this is what is going on you guys in a meeting from any real supervisor's and here read this. CNA Q revealed that, no she did not get to read the info in the binder at the employee door, it's just usually hurry up and sign in. Resident #1 According to Resident #1's face sheet dated [DATE] she was a [AGE] year-old female admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. Review of Resident #1's vital signs record revealed she had elevated temperatures on [DATE] at 1:06 AM (99.5 degrees Fahrenheit (F)), [DATE] at 3:31 AM (99.5 F), [DATE] at 6:25 AM (99.1 F), [DATE] at 7:28 PM (98.7 F) and [DATE] at 9:59 PM (97.9 F). According to Resident #1's progress note dated [DATE] at 2:26 Resident #1 was assessed. The note revealed her last temperature was taken on [DATE] at 9:59 PM (more than 4 hours prior to this assessment), her last pulse was taken on [DATE] at 1:40 AM (more than 24 hours prior to this assessment, her last blood pressure was taken on [DATE] at 1:40 AM (more than 24 hours prior to this assessment), and her last pulse was taken on [DATE] at 1:40 AM (more than 24 prior to this assessment. Resident #2 According to Resident #2's face sheet dated [DATE] she was a [AGE] year-old female last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. Review of Resident #2's progress notes dated [DATE] to [DATE] revealed no full lung assessments. Review of Resident #2's vital signs record [DATE] to [DATE] revealed her respiration were only assessed twice ([DATE] and [DATE]). There was no indication that her lung sounds were assessed from [DATE] to [DATE]. Resident #3 According to Resident #3's face sheet dated [DATE] he was a [AGE] year-old last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. Review of Resident #3 vital signs record from [DATE] to [DATE] revealed his oxygen saturation was 88% (percent) or below 10 times on room air. The record indicated he was provided oxygen on [DATE]. There was no indication oxygen had been provided despite oxygen saturation measurements of 88% or below starting on [DATE]. Review of Resident #3 progress notes from [DATE] to [DATE] revealed one lung assessment had been completed by the Resident #3's practitioner on [DATE] and documented he had decreased lower lung fields, productive cough, no fever, pulse oxygen was 90% on 6 liters of oxygen provided through a nasal cannula. This did not match the information in the vital signs record as there was no indication he was on oxygen. Another assessment was completed on [DATE] at 9:58 AM (this did indicate oxygen was on but not how many liters it was set at) and did not match the vital signs record which indicated he was on room air. The next assessment was dated [DATE] at 3:37 PM but used old vital signs pulse on [DATE] at 9:57 am, respirations on [DATE] at 9:57 AM, blood pressure on [DATE] at 2:32 AM, Oxygen on [DATE] at 12:12 PM (on room air), and no indication that lung sounds were assessed. The progress notes on [DATE] was the last note at an attempt to do a lung assessment. Resident #6 According to Resident #6's face sheet dated [DATE] he was an [AGE] year-old admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. Resident #6 was not his own responsible party. Review of Resident #6's progress notes from [DATE] to [DATE] revealed he had only one lung assessment documented the day of admission [DATE] at 10:34 PM. Resident #7 According to Resident #7's face sheet dated [DATE] she was a [AGE] year-old admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was her own responsible party. Record review revealed no respiratory screens for the first 48 hours. Review of the progress note dated [DATE] at 2:45 AM revealed old vital signs were documented in this assessment. Pulse, blood pressure and respirations were dated [DATE] at 7:11 PM. Resident #4 Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE] revealed Resident #4 admitted to the facility on [DATE]. Brief Interview for Mental Status (BIMS), reflected a score of 9 out of 15 which represents Resident #4 had moderate cognitive impairment. Record review of the electronic health record temperature log from [DATE] - [DATE] reflected no temperatures recorded for ,[DATE], ,[DATE], and ,[DATE]. Record review of the electronic health record oxygen saturation log from [DATE] - [DATE] reflected no oxygen saturation recorded for ,[DATE], ,[DATE] - [DATE]. Record review of the progress notes from [DATE] - [DATE] indicate that the resident refused or declined to have his temperature or oxygen saturation taken. During a telephone interview on [DATE] at 10:22 AM, the NHA stated that Resident #4 left the building on an independent leave of absence to smoke cigarettes just off the facility property, a few times a day. According to the self-sign log, Resident was gone anywhere from 30 to 90 minutes at a time. During a telephone interview on [DATE] at 3:08 PM, the NHA state