STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235481	A. BUILDING _____ B. WING _____	06/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKE ORION NURSING CENTER	585 EAST FLINT STREET LAKE ORION, MI 48362

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently monitor residents for physical symptoms of COVID-19 for 2 of 5 residents (Resident #4 and Resident #5) reviewed, resulting in Resident #4 and Resident #5 not being monitored for symptoms of COVID-19 according to the Centers for Disease Control and Prevention (CDC) guidelines and the facility's policy. Findings include: Resident #4 A review of Resident #4's face sheet, dated 6/10/20, revealed Resident #4 was an [AGE] year-old resident admitted to the facility on [DATE]. Resident #4 had multiple [DIAGNOSES REDACTED]. A review of Resident #4's laboratory test results, dated 5/9/20 to 6/10/20, revealed Resident #4 tested positive for COVID-19 on 5/19/20. A review of the Resident #4's electronic medical record (progress notes, physical assessments, observational assessments, Medication Administration Record, [REDACTED].g. chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea) on 5/6/20 to 5/12/20, 5/14/20, 5/16/20, 5/17/20, and 6/6/20. A review of the Resident #4's electronic medical record (progress notes, physical assessments, observational assessments, Medication Administration Record, [REDACTED].g. chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea) once on 5/5/20, 5/13/20 for pain and discomfort (in general), 5/15/20, 5/18/20, 5/19/20, 5/20/20, and 6/7/20. A review of the Resident #4's electronic medical record (progress notes, physical assessments, observational assessments, Medication Administration Record, [REDACTED].g. chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea) twice after testing positive for COVID-19 on 5/21/20, 5/22/20, 5/23/20, 5/24/20, 5/25/20, 5/27/20, 5/29/20, 5/31/20, 6/1/20, 6/2/20, 6/3/20, 6/5/20, and 6/8/20. A review of Resident #4's vitals report sheet, dated 5/5/20 to 6/10/20, revealed Resident #4 had been assessed for a fever (temperature readings) once on 5/6/20 and 5/12/20 and twice on 6/1/20 (after Resident #4 tested positive for COVID-19). During an interview on 6/9/20 at 10:30 AM, License Practical Nurse (LPN) H stated that every day the certified nursing assistant obtains a full set of vital signs (including an oxygen saturation) and the nursing staff ask questions and assess for COVID-19 symptoms such as pain, shortness of breath, cough, etc. LPN H stated the staff document the vital signs and nursing makes a progress note each day regarding the symptoms whether there were positive or negative (normal or abnormal) findings. On 6/10/20 at 9:46 AM, the Nursing Home Administrator (NHA) (who is also a Registered Nurse) was requested via e-mail to provide copies of all of Resident #4's assessments for physical symptoms of COVID-19 (e.g. cough, sore throat, muscle/body aches, nausea/vomiting, diarrhea, headache, chills, etc.) and any other documentation that would prove Resident #4 was assessed for physical signs and symptoms of COVID-19. During an interview on 6/10/20 at 1:35 PM, Infection Control Preventionist (ICP) G stated residents who test positive for COVID-19 have vital signs completed every 8 hours. In addition, ICP G stated the nurse will assess these residents for physical symptoms of COVID-19 once a day and write a nurse's note (progress note) in the electronic medical record. During an interview on 6/10/20 at 1:35 PM, ICP G was notified Resident #4's assessments for physical symptoms of COVID-19 could not be located in Resident #4's medical record for 5/6/20 to 5/12/20, 5/14/20, 5/16/20, 5/17/20, and 6/6/20. Copies of these assessments, or any additional documentation proving Resident #4 was assessed for physical signs or symptoms of COVID-19 that had not already been provided to this Surveyor, were requested from ICP G. As of the completion of the survey and the exit conference, the facility failed to provide any additional documentation Resident #4 had been assessed for physical signs or symptoms of COVID-19. During an interview on 6/10/20 at 3:45 PM, the Director of Nursing (DON) stated, We only document (in the medical record) by exception (i.e. the nurses only document negative assessment findings). However, except for documentation on 5/5/20, 5/29/20, and 5/31/20, all of Resident #4's nursing assessments and progress notes for physical symptoms of COVID-19 (e.g. chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea) had normal- based on Resident #4's medical [DIAGNOSES REDACTED]. Resident #5 A review of Resident #5's face sheet, dated 6/10/20, revealed Resident #5 was a [AGE] year-old resident admitted to the facility on [DATE]. Resident #5 had multiple [DIAGNOSES REDACTED]. A review of Resident #5's laboratory test results, dated 5/9/20 to 6/10/20, revealed Resident #5 tested negative for COVID-19 on 5/12/20. A review of Resident #5's progress notes, dated 5/6/20 to 6/10/20, revealed Resident #5 went to the hospital emergency roiagnom on [DATE] at 5:57 PM for [MEDICAL CONDITION] (lack of oxygen), malaise (fatigue), and a temperature of 102.7* Fahrenheit. In addition, Resident #5's progress notes revealed Resident #5 returned to the facility on [DATE] at 4:05 PM with a [DIAGNOSES REDACTED]. A review of the Resident #5's electronic medical record (progress notes, physical assessments, observational assessments, Medication Administration Record, [REDACTED].g. chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea) on 5/6/20, 5/7/20, 5/30/20, 6/2/20, 6/3/20, 6/4/20, 6/6/20, and 6/7/20. A review of the Resident #5's electronic medical record (progress notes, physical assessments, observational assessments, Medication Administration Record, [REDACTED].g. chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea) once on 5/8/20, 5/9/20 (pain in general), 5/10/20, 5/11/20, 5/12/20 ([MEDICAL CONDITION] only), 5/13/20, 5/27/20, 6/1/20, 6/5/20, 6/8/20, and 6/9/20. A review of Resident #5's vitals report sheet, dated 5/5/20 to 6/10/20, revealed Resident #5 had only been assessed for a fever (a symptom of COVID-19) once on 5/9/20 and 5/26/20. During an interview on 6/9/20 at 10:30 AM, License Practical Nurse (LPN) H stated that every day the certified nursing assistant obtains a full set of vital signs (including an oxygen saturation) and the nursing staff ask questions and assess for COVID-19 symptoms such as pain, shortness of breath, cough, etc. LPN H stated the staff document the vital signs and nursing makes a progress note each day regarding the symptoms whether there were positive or negative (normal or abnormal) findings. On 6/10/20 at 9:46 AM, the Nursing Home Administrator (NHA) (who is also a Registered Nurse) was requested via e-mail to provide copies of all of Resident #5's assessments for physical symptoms of COVID-19 (e.g. cough, sore throat, muscle/body aches, nausea/vomiting, diarrhea, headache, chills, etc.) and any other documentation that would prove Resident #4 was assessed for physical signs and symptoms of COVID-19. During an interview on 6/10/20 at 1:35 PM, Infection Control Preventionist (ICP) G stated residents who test negative for COVID-19 or who have not been tested and do not have symptoms of COVID-19 have vital signs (blood pressure, pulse, respirations, temperature, and pulse oximetry (measure of oxygen level in the blood with a probe that attaches to the finger)) completed twice a day. In addition, ICP G stated the nurse will assess these residents for physical signs and symptoms of COVID-19 once a day and write a nurse's note (progress note) in the electronic medical record. During an interview on 6/10/20 at 1:35 PM, ICP G was notified Resident #5's assessments for physical symptoms of COVID-19 could not be located in Resident #5's medical record for 5/6/20, 5/7/20, 5/30/20, 6/2/20, 6/3/20, 6/4/20, 6/6/20, and 6/7/20. Copies of these assessments, or any additional documentation proving Resident #5 was assessed for physical symptoms of COVID-19 that had not already been provided to this Surveyor, were requested from ICP G. As of the completion of the survey and the exit conference, the facility failed to provide any additional documentation Resident #5 had been

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) assessed for physical symptoms of COVID-19. During an interview on 6/10/20 at 3:45 PM, the Director of Nursing (DON) stated, We only document (in the medical record) by exception (i.e. the nurses only document negative assessment findings). However, except for documentation on 5/26/20, 5/27/20, and 6/9/20, all of Resident #5's nursing assessments and progress notes for physical symptoms of COVID-19 (e.g. chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea) had normal- based on Resident #5's medical [DIAGNOSES REDACTED]. A review of the facility's Monitoring for Signs and Symptoms of COVID-19 policy, undated, revealed, Every resident will have vital signs taken each shift and documented under vital signs in the EHR (electronic health record). Vital signs will include blood pressure, pulse, respirations, temperature, and pulse oximetry. Additionally, every resident will be assessed for respiratory symptoms and gastrointestinal symptoms every shift. A review of the facility's Monitoring for Signs and Symptoms of COVID-19 policy, undated, revealed, Every resident diagnosed with [REDACTED]. Vital signs will include blood pressure, pulse, respirations, temperature, and pulse oximetry. Additionally, every resident diagnosed with [REDACTED]. A review of the Centers for Disease Control and Prevention (CDC)'s web page, Preparing for COVID-19 in Nursing Homes, dated 5/19/20, revealed, Actively monitor all residents upon admission and at least daily for fever (T=100.0* F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions . Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >99.0* F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19 . If COVID-19 is suspected, based on evaluation of the resident or prevalence of COVID-19 in the community . 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 infection. Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any with new symptoms. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html#facilities-should-do). A review of the Centers for Disease Control and Prevention (CDC)'s web page, Symptoms of Coronavirus, dated 5/13/20, revealed, People with COVID-19 have had a wide range of symptoms reported - ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to [MEDICAL CONDITION]. People with these symptoms may have COVID-19: Fever or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Sore throat, Congestion or runny nose, Nausea or vomiting, Diarrhea. This list does not include all possible symptoms. (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html).