STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235623	A. BUILDING _____ B. WING _____	08/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROYALTON MANOR, L L C	288 PEACE BLVD ST JOSEPH, MI 49085

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 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** This citation pertains to intake MI 312 Based on interview and record review, the facility failed to develop person-centered care plans during a combined abbreviated and COVID-19 Infection Control survey for 3 of 15 residents (Resident #101, Resident #108, and Resident #111) reviewed for care plan development, resulting in a lack of service for residents to maintain their highest practicable physical, mental, and psychosocial well-being . Findings include: Review of facility policy Care Plan dated ,[DATE], revealed, Purpose Every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs identified in the comprehensive assessments and prepared by an interdisciplinary team who includes but not limited to; attending physician, a registered nurse who is responsible for the resident, a nurse aide, a member of food/nutrition services, the resident or resident representative, therapy staff as required and any other ancillary staff. Additional resources will also be utilized to ensure that any additional needs or risk areas are identified. Procedure l. Resident's will be assessed as they are admitted and readmitted to the nursing facility to determine their physical, psychological, emotional, medical, and psychosocial needs. The results of interdisciplinary assessments will be used to develop, review, and revise the resident's comprehensive care plans. 2. A Baseline Care Plan will be developed within 48 hours identifying any immediate needs, initial goals and interventions needed to provide effective and person-centered care .In addition to care plans based on admission orders [REDACTED]. Some care plans stand alone and are unique . 7. The care plan must be specific, resident centered, individualized and unique to each resident. How to manage risk factors . Involve and communicate the needs of the resident with the direct care staff (i.e. CNA kardex) .9. The care plan and resident kardex will be updated on Admission, Quarterly, Annually and with significant changes. This includes adding new focuses goals and interventions . Resident #101 Review of a complaint received on [DATE] at 09:19, facility staff had allegedly found over 130 medication pills in Resident #101's belongings including medications found by the medical examiner on her person upon her death on [DATE] at 6:18 AM. Review of Resident #101's Resident, Family, Employee, and Visitor Assistance Form dated [DATE], revealed, .While cleaning (Resident #101's) belongings, I found over 100 pills stuffed in nearly every single drawer of her room along with inside TV box and more to be found . Review of a Admission Record revealed Resident #101 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 6 out of a total possible score of 15, which indicated Resident #101 was severely cognitively impaired. Further review the MDS indicated Resident #101 was independent in her ability to transfer herself from her bed and in walking in her room and around the facility. The MDS indicated Resident #101 health conditions included hypertension, heart failure, diabetes mellitus, [MEDICAL CONDITION], stroke, non-Alzheimer's dementia, [MEDICAL CONDITION], and asthma. Review of Resident #101's Care Plans identified her as a hoarder (excessive accumulation of items) and collected a variety of items. As part of her treatment plan, a goal was put in place on [DATE] to allow staff to clean hoarded items. To achieve this goal, interventions to check resident's room on a regular basis, clean hoarded items that might pose a health or safety risk and encourage resident to clean/remove the unneeded items were put in place on [DATE] as well. Resident #101's Care Plan also indicated the resident was at risk for cardiac complication related to multiple cardiovascular diseases and took multiple medications as part of her treatment. The goal initiated on [DATE] was to keep the resident free from signs and symptoms of cardiac complications with interventions including administering medications per order which was also initiated on [DATE]. According to https://medical-dictionary, cheeking a medication is, . concealing a medication in the mouth, i.e., between the teeth and the cheek, in order to avoid swallowing it . During an interview on [DATE] at 2:30 PM, LPN K stated, I was working on the day (Housekeeping F) found the pills in (Resident #101's) pills. I went through (Resident #101's) belongings and found more pills. There was probably a water cup, about a 6-ounce size, almost full of pills. I asked (DON B) what to do with them and she said to just put them in the drug buster to dispose of them. I did not write up an incident report or document I found them or what I did with them. I have given (Resident #101) medication before. Once, after I had left her room and given her some pills, she came out to the nursing station where I was at, and when she looked at me I could tell she had pills in her mouth. It was probably 15 minutes after I had given them to her. I told her she had to swallow them. I never put it on her care plan or documented that she had cheeked her meds. Resident #108 Review of a Face Sheet revealed Resident #108 was a [AGE] year-old male, re-admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #108, with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #108 was cognitively intact. Review of Resident #108's Care Plans indicated on [DATE] with a revision on [DATE], a focus with goals and interventions for activities was put in place to stay in his room by following the recommended guidelines in response to COVID-19. Further review of the care plan did not reveal Resident #108 had been placed on transmission-based precautions of contact and droplet isolation after his admit back to the facility on [DATE]. Review of the resident's Kardex did not include potential COVID-19 exposure transmission-based precautions of contact and droplet isolation alerting to CNA staff to provide person-centered care safely for both the resident and staff. Review of email correspondence from Nursing Home Administrator (NHA) A on [DATE] at 3:57 PM revealed, . (Resident #108) [DATE] 10:40 PM to ER (emergency room) return [DATE] at 4:45 AM return to room ,[DATE] with roommate (Resident #110) Review of Resident #108 Progress Notes revealed, Nursing Summary [DATE] 2104 (9:04) pt (patient) came back to .room ,[DATE] .on 2-week isolation . Resident #111 Review of a Face Sheet revealed Resident #111 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED].#111, with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #111 was moderately cognitively intact. Review of Resident #111's Order Summary Report revealed, .Contact and Droplet Isolation (Transmission Based Precautions) r/t COVID-19 every shift for [MEDICATION NAME] until [DATE] 14:59 Active Order Date [DATE] Start Date [DATE] End date [DATE] . Review of Resident #111's Care Plan and Kardex revealed that the order of placing the resident on transmission-based precautions including contact and droplet isolation were not reflected to guide the person-centered care of the nursing staff. Review of Resident #111's Progress Notes revealed, Nursing Summary [DATE] 1412 (2:12 PM) .pt (patient) arrived .all orders were confirmed . Review of email correspondence from Nursing Home Administrator (NHA) A on [DATE] at 3:57 PM revealed, (Resident #111) ,[DATE] (2020) 10:22 PM went to ER. ,[DATE] (2020) 3:20 PM returned from ER room ,[DATE] with a roommate. During an interview on [DATE] at 10:30 AM, Director of Nursing (DON) B stated, Care plans tell nursing staff how to direct patient care. Any nursing staff can add or update a care plan. If a staff knew

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

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F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) (Resident #101) cheeked medications or hid them, it should have been care planned and told to staff.

F 0658

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure services provided by the nursing facility meet professional standards of quality.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

This citation pertains to intake MI 312 Based on observation, interview, and record review, the facility failed to ensure residents received medications in accordance with professional standards of nursing practice for 3 of 3 sampled residents (Resident #101, Resident #102, Resident #103) reviewed standards of care, resulting in resident's medication not being consistently taken and/or not being monitored during administration, resulting in the potential of decreased effectiveness of medications and the affected residents not maintaining or achieving their highest practical physical well-being.

Findings include: Review of facility policy, Medication Self-Administration, Long-Term Care Revised: [DATE], revealed, .A standard procedure should be established for a resident to self-administer medications to ensure resident safety, promote medication effectiveness, and provide adequate documentation of adherence with the medical treatment plan . Obtain a practitioner's order for self-administration of medications . According to https://www.registerednursing.org/nclex/medication-administration/, Preparing and Administering Medications and Using the Rights of Medication Administration . The Ten Rights of Medication Administration are the right, or correct: 1. Medication 2. Dose 3. Time or frequency 4. Patient 5. Route 6. Client education 7. Documentation 8. Right to refuse 9. Assessment and 10. Evaluation . In addition to the Ten Rights of Medication Administratio . nurses must also insure medication safety in respect .the checking for expiration dates . Administering and Documenting Medications Given by a Common Route . Oral Route Administration Give the patient the medication. Remain with the patient until the medication is swallowed; some clients may pocket and store medications in their cheeks rather than swallow them . Documenting Medications Given Using All Routes .

Nurses are legally and ethically responsible and accountable for accurate and complete medication administration, observation, and documentation . Resident #101 Review of a complaint received on [DATE] at 09:19, staff had allegedly found over 130 medication pills in Resident #101's belongings including medications found by the medical examiner on her person upon her death on [DATE] at 6:18 AM. Review of Resident #101's Resident, Family, Employee, and Visitor Assistance Form dated [DATE], revealed, .While cleaning (Resident #101's) belongings, I found over 100 pills stuffed in nearly every single drawer of her room along with inside TV box and more to be found . Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 6 out of a total possible score of 15, which indicated Resident #101 was severely cognitively impaired. Further review the MDS indicated Resident #101 was independent in her ability to transfer herself from her bed and in walking in her room and around the facility. The MDS indicated Resident #101 health conditions included hypertension, heart failure, diabetes mellitus, [MEDICAL CONDITION], stroke, non-Alzheimer's dementia, [MEDICAL CONDITION], and asthma. Review of Resident #101

Physician Statement of Competency dated ,[DATE], indicated that two (2) licensed professionals, one being a M.D., declared the resident .incompetent and unable to make his/her informed medical decisions . Review of Resident #101's Progress Note dated [DATE] 15:31 (3:31 PM) revealed, Social Services Note .she voiced some paranoia as well as she stated someone might be poisoning her .SW (social worker) made floor nurse aware of (resident name) current mood/symptoms, as well as medial and psych NP. SW will follow. Review of Resident #101's Care Plans identified her as a hoarder (excessive accumulation of items) and collected a variety of items. As part of her treatment plan, a goal was put in place on [DATE] to allow staff to clean hoarded items. To achieve this goal, interventions to check resident's room on a regular basis, clean hoarded items that might pose a health or safety risk and encourage resident to clean/remove the unneeded items were put in place on [DATE] as well. Resident #101's Care Plan revealed she was at risk fluctuation in blood sugar levels related to diabetes mellitus and required oral diabetic medication. The goal of this focus was for the resident to have no complications related to diabetes and be free of hypo/[MEDICAL CONDITION] and complications from fluctuating blood sugar levels. An intervention to achieve these goals were to administer medication as ordered. The original focus, goal, and intervention were initiated [DATE]. Resident #101's Care Plan also indicated the resident was at risk for cardiac complication related to multiple cardiovascular diseases and took multiple medications as part of her treatment. The goal initiated on [DATE] was to keep the resident free from signs and symptoms of cardiac complications with interventions including administering medications per order which was also initiated on [DATE]. Review of Resident #101's Medication Administration Record [REDACTED]. During an interview on [DATE] at 11:06 AM Housekeeping F stated, When cleaning resident room, I only go through belongings if a resident requests assistance. I cleaned Resident #101's room for a about a month and half, 5 days a week. I saw 2 pills under her dresser while cleaning during that time. I told the nurse that was taking care of her at that time.

When Resident #101 passed, the coroner went the nursing station and said she found medication in her clothing pocket. I was assigned to sanitize her room after Resident #101's passing. I first started cleaning the plastic 3-drawer dresser and started finding pills. All together I found 165 pills while cleaning out the plastic 3-drawer dresser and 2 other wooden dressers. I reported to my (Laundry O) first and she said to tell someone I trust. I showed her the pills in the plastic dresser first. I had not looked in the other dressers yet because I knew I had to have a witness. (Laundry O) and I decided to go tell (LPN K). He went to the room with me and told me the pills did not look like they had been spat out. He collected them all from the plastic dresser at that time and put them in a cup. I know he did not find all the pills at that time. (Resident #101) had them hid under her clothing in the dressers, in a TV box with blankets, under food in a box. She had the pills hid under all her belongings. I told (LPN K) I need to report this. He told me, he took the pills to (DON B), and said he didn't know what to do. I filled out a concern form and gave it to the facility administrator. The administrator said that (Resident #101) was very sick and not getting up out of bed, but I saw her out of bed every day. (Resident #101) was already caught spitting out medications because the administrator and director of nursing had tried to give her medications themselves. The administrator explained (Resident #101) would have catastrophic reactions and refuse to take her pills if anyone was in the room. So, I assumed the pills would have to have to be left in the room. I do not know how 165 pills would have gotten there if not. When the administrator told me, it was a failure on all the departments because it was obvious housekeeping didn't clean the dressers out when (Resident #101) was alive it was a shock. (Resident #101) did not like people getting into her belongings. I was told by nursing staff it was care planned she did not like people going into her things. If a resident tells me not to touch their things I do not. If a resident will not let housekeeping clean for a few days' housekeeping is to go to the supervisor who will investigate the situation. There are care plans that housekeeping not allowed to throw items out. I did have to sign that I was satisfied with the solution and felt I had to or else I felt I would lose my job. The administrator told me the pills were old and not recent pills. The administrator never asked me to make a witness statement. During an interview on [DATE] at 2:30 PM, LPN K stated, I was working on the day (Housekeeping F) found the pills in (Resident #101's) pills. I went through (Resident #101's) belongings and found more pills. There was probably a water cup, about a 6-ounce size, almost full of pills. I asked (DON B) what to do with them and she said to just put them in the drug buster to dispose of them. I did not write up an incident report or document I found them or what I did with them. I have given (Resident #101) medication before. Once, after I had left her room and given her some pills, she came out to the nursing station where I was at, and when she looked at me I could tell she had pills in her mouth. It was probably 15 minutes after I had given them to her. I told her she had to swallow them. I never put it on her care plan or documented that she had cheeked her meds. During an interview on [DATE] at 9:00 AM, State Police Officer U stated, The medical examiner (ME) told me she found pills on the deceased after our visit to the facility. During an interview on [DATE] at 9:39 AM, Registered Nurse (RN) R stated, I have been educated on medication administration. I watch residents take their medications. The nurse can give the resident their meds and they can pour them in their mouth, but the nurse needs to watch them. (Resident #101) took her medications by mouth. I would talk to her and wake her up and tell her what meds she was getting. I never saw her cheek meds. You can tell when a resident has meds in their mouth. No one ever said they knew (Resident #101) cheeked meds or found pills in her room. I was assigned to (Resident #101) on the night she died . During an interview on [DATE] at 9:58 AM, Certified Nurse Assistant (CNA) Q stated, (Resident #101) would have incidents of acting out behaviors but not with me. I knew she would give some nurses problems taking meds. Sometimes she would take her meds and sometimes she would not. During an observation and interview on [DATE] at 10:30 AM with Nursing Home Administrator (NHA) A and Director of Nursing (DON) B, DON B stated, (Resident #101) kept a lot of things in her room. She was like a hoarder. She did not like people going through her things. She would not let you go through her things or put her clothes away. She took care of her toileting and bathing, dressing, and eating. No staff ever told me she cheeked her medications or that any were found in her belongings. I didn't know anything about her having kept all of the medications found. A nurse should make sure a resident swallows medications when they are given. There is no reason this should not be done. Residents in this facility do not self-administer medications. Medications are

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) not to be left with the resident or at bedside, ever. DON B stated, Nurses have been given education and training on medication administration. A resident should never be left alone with medications. During an interview on [DATE] at 11:24 AM Registered Nurse (RN) L stated, (Resident #101) did not like to take medication. She would say people were trying to poison her. I did not hear she cheeked her medications. No one ever said anything about it. If they knew they should have said something. During an interview on [DATE] at 11:49 AM, Nurse Practitioner (NP) T stated, I was one of (Resident #101's) providers. I worked with her medications. I have a peer relationship with staff and collaborate with resident cares. If staff sees something, they come to me with it. She did not like the idea of being in a nursing home. As far as I know, there were days she refused medications. She would resist care at times. No staff ever said anything to me about her keeping her medications in her room. Over one hundred pills, is a lot of pills. Normally when the nurse goes to give medications, they are to watch the resident take the medications (meds). Depending on what medication is not taken consistently there could be problems. If the medications were [MEDICAL CONDITION] meds, it could cause an increase in behaviors, absence of heart meds could increase blood pressure. You would have to know what meds the resident was not getting and how over time it would affect the resident. (Resident #101) was showing more increased agitation. During an interview on [DATE] at 1241 PM Medical Examiner E stated, In the notes regarding (Resident #101), it was documented by the medical examiner a med cup was found in right pants pocket with several pills in it. At this time the medical document was requested and received via email. Review of Resident #101's Investigative Report Case: ,[DATE]-JL-293-BE dated [DATE], revealed Antemortum Events .On [DATE], the decedent received her nighttime medication at 2100 .Medical/Social History . currently taking [MEDICATION NAME], carvedilol, [MEDICATION NAME]-salmeterol, [MEDICATION NAME] sodium, [MEDICATION NAME], [MEDICATION NAME] HCl, [MEDICATION NAME], NAME], [MEDICATION NAME], and [MEDICATION NAME]. RN (Registered Nurse (RN) R) stated that she (referring to Resident #101) was compliant with taking her medications, but I did find a pill cup with several pills in her right pants pocket that was not taken . During an interview on [DATE] at 12:48 PM, Housekeeping/Laundry Supervisor X stated, I found a total of 30 pills in (Resident #101's) belongings. The pills were found as I was packing up the belongings. They were all over in different hiding spots. I had her whole room to pack up and she had a lot of clothes. As I was going through her garments, I kept looking for pills and got tired after a while of looking for them there so many. Neither my staff nor I knew she was hiding the pills. She did not want anyone going through her things and needed to trust you before letting you even in her room. (Housekeeping F) found a lot of pills, more than I did. (LPN K) found quite a few as well. Resident #102 During an observation and interview on [DATE] at 12:57 PM Resident #102 was sitting in a wheelchair next to her bed. Lying on the foot-of-the bed was an [MEDICATION NAME] Diskus ([MEDICATION NAME]-Salmeterol Aerosol Powder Breath). Resident stated, I have asthma. The nurse left it in my room this morning for me to use. She usually stays with me until I take my medications. Review of an Admission Record revealed Resident #102 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 10, out of a total possible score of 15, which indicated Resident #102 was cognitively impaired. Further review of the MDS indicated Resident #102 had [MEDICAL CONDITION] embolism without acute cor pulmonale. Review of Resident #102's Physician order [REDACTED]. Review of Resident #102's Medication Administration Record [REDACTED]. Review of resident's Progress/Nurses Notes revealed that no documentation was entered on [DATE] regarding the administration of medication. Further review of residents MAR indicated [REDACTED]. Review of Resident #102's Care Plans indicated the resident was not care-planned to self-administer medications. During an observation and interview on [DATE] at 1:15 PM, Licensed Practical Nurse (LPN) C stated, There are no residents that self-administer medications on my unit. I don't think any resident can self-administer medication in this facility. Noted LPN C was assigned to administer medications to Resident #102 on [DATE] on first shift. Observed with LPN C on the foot of resident's bed the medication [MEDICATION NAME] Diskus. LPN C picked it up and stated, It must have gotten left here last night because I did not administer it today. Observed on the back of the diskus printed in black was the residents room number and it was dated. LPN C stated, I need to ask the unit manager who this [MEDICATION NAME] belongs to. Again, observed the back of the discus with LPN C who stated, It is (Resident #102's). There is a box in the medication cart for it. Observed in the Central Medication Cart (med cart) with LPN C an [MEDICATION NAME] Diskus box labeled with Resident #102's name and information. When asked why the medication would be on a made bed, LPN C asked Certified Nursing Assistant (CNA) D who stated, I made (Resident #102's) bed this morning and I did not put it (referring to the medication) there. LPN C stated, The medication must have been left in the bedside table or somewhere for the resident to get it. Resident #103 Review of a Face Sheet revealed Resident #103 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 3, out of a total possible score of 15, which indicated Resident #103 was severely cognitively impaired. During an interview on [DATE] at 11:06 AM Housekeeping F stated, The facility administrator told me to watch (Resident #103's) room because her family had found cups of pills twice in trash. Review of facility Educational Opportunity dated [DATE], revealed, .(Registered Nurse E) Facts surrounding educational opportunity: Resident, Family, Employee, Visitor Form Admin Vol 1:207 completed reported medications were found in resident's room on [DATE] .Policy/work rule(s): Medication Administration General Guidelines states: Do Not leave meds with resident and don't leave until meds have been swallowed. During an interview on [DATE] at 3:00 PM, RN E stated, I always make sure residents take their pills when I give them. I do not leave the pills with them. I've received education and training on administration of medication. During an interview on [DATE] at 11:24 AM Registered Nurse (RN) L stated, When administering medications, I ask the resident if they swallowed it; you can tell if they did or not. There are no residents that self-administers medications in this facility. I have seen meds left for residents. There were a couple of times (Resident #103's) family said they had found a couple of pills in her room. When I went into her room, I found pills on her bedside table. The nurse was (RN E). I was the staff educator at that time and had to give her education on not leaving medication with the resident.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **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 properly maintain infection control practices during a combined abbreviated and COVID-19 Infection Control Survey, per CDC (Centers for Disease Control) recommendations for COVID-19 of 1.) hand hygiene for 3 of 15 sampled residents (Resident #105, Resident #106, and Resident #114) reviewed for infection control, 2.) proper PPE (personal protection equipment) face shield implementation was utilized correctly and disinfected for 2 of 15 sampled residents (Resident #114 and Resident #111) reviewed for infection control, 3.) implement isolation precautions for 2 readmitted residents (Resident #105 and Resident #110) for Transmission-based Precautions per the Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid guidelines from a total of 15 sampled residents reviewed for infection control, and 4.) provide a facility Infection Control Preventionist to ensure surveillance and monitoring of the facility infection control program, resulting in the potential for cross-contamination, development, and spread of contagious and infectious disease and illnesses of, placing all residents who are susceptible, elderly, and/or physically compromised at risk for serious harm, injury and/or death. Findings include: According to https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, Implement Source Control Measures . Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if PPE is required . Identify Space in the Facility that Could be Dedicated to Monitor and Care for Residents with COVID-19 . Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown . As roommates of residents with COVID-19 might already be exposed, it is generally not recommended to place them with another roommate until 14 days after their exposure, assuming they have not developed symptoms or had a positive test .Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown. Cloth face coverings are not considered PPE and should not be worn when PPE is indicated . Hand Hygiene-Medication Administration Review of facility policy, HAND HYGIENE revised ,[DATE], revealed, Policy: To decrease the risk of transmission of infection by appropriate hand hygiene. Hand washing/hand hygiene is generally considered the most important single procedure for preventing healthcare-associated infections. Antiseptics control or kill microorganisms contaminating skin and other superficial tissues and are sometimes composed of the same chemicals that are used for disinfection of inanimate objects. Although antiseptics and other hand washing/hand hygiene agents do not sterilize the skin, they can reduce microbial contamination depending on the type and the amount of contamination, the agent used, the presence of residual activity and the handwashing/hand hygiene technique followed. HANDWASHING When hands are visibly dirty or contaminated with

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 3) proteinaceous material, are visibly soiled with blood or other body fluids, .use soap and water. May use Alcohol based hand sanitizer before and after touch a guest/resident, before performing an aseptic task or handling invasive medical devices, after glove removal, if moving from a contaminated body site to a clean body site during guest/resident care, and after contact with blood, body fluids or contaminated surfaces. Turn on water to a comfortable warm temperature. Moisten hands with soap and water and make a heavy lather. Wash well under running water for a minimum of 20 seconds, using a rotary motion and friction. Rinse hands well under running water. Dry hands with a clean paper towel. Use the paper towel to turn off the faucet, and then discard . Resident #106 Review of a Face Sheet revealed Resident #106 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #106 was cognitively intact. During an observation on [DATE] at 10:05 AM, Licensed Practical Nurse (LPN) S prepared medications (med) from med cart for Resident #106. Upon entering the resident's room, LPN S donned gloves without performing hand hygiene. After all medication was administered, LPN S doffed the gloves and washed her hands for four (4) seconds under running water. Resident #105 Review of a Face Sheet revealed Resident #105 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Chronic [DIAGNOSES REDACTED] is a severe, persistent, incapacitation infection of bone, which develops after two months of an injury or initial infection .The common signs and symptoms are pain and movement restriction .Treatments .include antibiotic . (sic) Tangella, K. MD ([DATE]). Chronic [DIAGNOSES REDACTED]. Retrieved from http://dovemed.com Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 00, out of a total possible score of 15, which indicated Resident #105 was cognitively unable to complete the interview. Review of Resident #105's Facility-Initiated Transfer for Nursing Homes dated [DATE], indicated the resident was sent to the hospital for behavioral needs cannot be met in the nursing home became combative with care pulled out PICC line during (antibiotic) administration . During an observation and interview on [DATE] at 10:25 AM, LPN S prepared medications for Resident #105 including an antibiotic that was to be administered through a medication pump and into his blood stream via a PICC line. Upon entering the resident's room, LPN S placed a med cup containing by mouth medications, and IV antibiotic on bedside table without a barrier. Without performing hand hygiene, LPN S donned gloves, replaced IV tubing, flushed tubing with normal saline, uncapped the PICC port and placed an end of the new tubing in it. LPN S then touched the pump several times to start it and to keep it from sounding an alarm. Then with same gloves on reached into shirt pocket to retrieve a black marker and write on a label, placing it back into her pocket when finished. LPN S then used the bed controller to raise resident's head-of-bed with gloved hands and began to administer oral medications. With same gloves on, LPN S touched resident's drink straw at the tip of it several times to place it in his mouth both while administering meds and when resident began to cough. After administering medications, LPN S placed clean IV supplies at bedside and on IV pump, then administered a nasal spray with same gloves on. After bagging up bedside garbage, LPN S doffed gloves and washed hands with soap and water for 30 seconds. LPN S stated, Hand hygiene should be done before and after passing medications. When administering medications via a PICC line, hands should be sanitized before and after just like when you put gloves on or take them off. I should have used hand sanitizer before putting my gloves on. Resident #111 Review of a Face Sheet revealed Resident #111 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED].#111, with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #111 was moderately cognitively intact. Review of Resident #111's Order Summary Report revealed, .Contact and Droplet Isolation (Transmission Based Precautions) r/t COVID-19 every shift for [MEDICATION NAME] until [DATE] 14:59 Active Order Date [DATE] Start Date [DATE] End date [DATE] . Resident #114 Review of a Face Sheet revealed Resident #114 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #114, with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #114 was cognitively intact. Review of Resident #114's Progress Note Nursing Summary dated [DATE] 17:36 (5:36 PM) revealed, Pt (patient/resident) admitted to (name of facility) to room ,[DATE] from (name of hospital) . During an interview on [DATE] at 3:00 PM, Director of Nursing (DON) B stated, Rooms .112 . have isolation residents from the hospital in them for 14-days. During an observation and interview on [DATE] at 12:30 PM, Certified Nursing Assistant (CNA) P donned a face shield while wearing a cloth face covering (not N95) that only covered her mouth and not her nose, donned a blue gown, and gloves without performing hand hygiene, then entered Resident #111's room. Upon exiting resident's room, CNA P carried a lunch tray from the room without performing hand hygiene and using a napkin to hold the tray in her right hand. After placing the tray with items on it into the community tray cart, CNA P came back to the isolation cart between Resident #111's and Resident #114's room and removed the face shield and stated, These masks are hard to wear. I cannot breathe good. I have to wear it like this. I cannot always wear it over my nose. I do not know if I am to clean the face shield or with what. I just came back to work. I should have cleaned my hands. Both Resident #111's and Resident #114's room door had signage identifying full personal protection equipment (PPE) must be worn at all time when in this room It was noted Resident #114's room door was open to the hall before CNA P entered and was left open after she exited. During an interview on [DATE] at 1:03 PM Licensed Practical Nurse (LPN) C, stated, Staff have to have a mask on when you enter the building. The mask is to cover both nose and mouth or else [MEDICAL CONDITION] (referring to COVID-19) could be spread. According to the Center for Disease Control (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html), Selected Options for Reprocessing Eye Protection: Adhere to recommended manufacturer instructions for cleaning and disinfection. When manufacturer instructions for cleaning and disinfection are unavailable, such as for single use disposable face shields, consider: 1. While wearing gloves, carefully wipe the inside, followed by the outside of the face shield or goggles using a clean cloth saturated with neutral detergent solution or cleaner wipe. 2. Carefully wipe the outside of the face shield or goggles using a wipe or clean cloth saturated with EPA-registered hospital disinfectant solution. 3. Wipe the outside of face shield or goggles with clean water or alcohol to remove residue. 4. Fully dry (air dry or use clean absorbent towels). 5. Remove gloves and perform hand hygiene . COVID-19 Transmission-Based Precautions Contact/Droplet Precautions According to https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html, .Ideally the unit should be physically separated from other rooms or units housing residents without confirmed COVID-19 .care unit could be a separate floor, wing, or cluster of rooms . Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19. All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown . New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission) . According to the Centers for Disease Control (CDC), Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) revealed, Clinical Presentation: Incubation period. The incubation period for COVID-19 is thought to extend to 14 days, with a median time of ,[DATE] days from exposure to symptoms onset. One study reported that 97.5% of persons with COVID-19 who develop symptoms will do so within 11.5 days of [DIAGNOSES REDACTED]-CoV-2 infection. Presentation: The signs and symptoms of COVID-19 present at illness onset vary, but over the course of the disease, most persons with COVID-19 will experience the following: Fever (,[DATE]%) Cough (,[DATE]%) Fatigue (,[DATE]%) Anorexia (,[DATE]%) Shortness of breath (,[DATE]%) Sputum production (,[DATE]%) Myalgia (,[DATE]%) Atypical presentations have been described, and older adults and persons with medical comorbidities may have delayed presentation of fever and respiratory symptoms. According to CDC (Centers for Disease Control) at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, .When relaxing any restrictions, nursing homes must remain vigilant for COVID-19 among residents and HCP (health care professionals) in order to prevent spread and protect residents and HCP from severe infections, hospitalization s, and death . According to CDC (Centers for Disease Control) at https://www.cms.gov/files/document/qso-,[DATE]-nh.pdf, .Given the critical importance in limiting COVID-19 exposure in nursing homes, decisions on relaxing restrictions should be made with careful review of a number of facility-level, community, and State factors/orders, and in collaboration with State and/or local health officials and nursing homes. Because the pandemic is affecting communities in different ways, State and local leaders should regularly monitor the factors for reopening and adjust their plans accordingly. Factors that should inform decisions about relaxing restrictions in nursing homes include .Case status in the nursing home(s): Absence of any new nursing home onset of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235623	A. BUILDING _____ B. WING _____	08/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROYALTON MANOR, L L C	288 PEACE BLVD ST JOSEPH, MI 49085

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** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 4) COVID-19 cases (resident or staff), such as a resident acquiring COVID-19 in the nursing home . Dedicated space in facility for cohorting and managing care for residents with COVID-19; plan to manage new/readmissions with an unknown COVID-19 status and residents who develop symptoms .A nursing home may be in different phases than its surrounding community based on the status of COVID-19 inside the facility .For example, if a facility identifies a new, nursing home onset COVID-19 case in the facility while in any phase, that facility goes back to the highest level of mitigation, and starts over (even if the community is in phase 3) . During an interview on [DATE] at 2:30 PM, NHA A stated, When (Resident #105) went out to the hospital on [DATE] and came back after evaluation, he was placed back into his same room. (Resident #105) was not put on transmission-based precautions isolation. If the hospital staff said he wore his mask 100% of the time then the facility nurse taking the report would document it in a progress note and the resident would not have to be put in isolation for 14-days. When asked how the facility knew if Resident #105 wore his face covering 100% of the time on his way to and from the hospital, NHA A did not answer and stared at surveyor. Review of Resident #105's medical records did not have documentation pertaining to the resident's trip to the hospital that he had worn his face covering 100% of the time there, nor during his trip from the hospital. Resident #108 Review of a Face Sheet revealed Resident #108 was a [AGE] year-old male, originally admitted to the facility on [DATE] and readmitted on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #108, with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #108 was cognitively intact. Resident #110 Review of a Face Sheet revealed Resident #110 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #110, with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #110 was cognitively intact. Review of Resident #110's Care Plans indicated Activities focus, goals, and interventions were specific to the COVID-19 precautions dated [DATE]. Further review of the care plan, revealed on [DATE] the focus .has the potential for developing COVID-19 infection current pandemic .Goal: Will remain free of signs/symptoms of COVID-19 . During an interview on [DATE]/2020 at 12:16 PM Director of Nursing (DON) B stated, The facility does not have a COVID-19-unit per say. If a positive case of COVID-19 were in the facility we would have to send them out if the hospital would take them. The HUBs (facility's designated to care for Covid-19 residents) are in (another citiy) and not around here. The isolation rooms are throughout this hall, (100). They are new admits and have to stay in quarantine for 14-days even though they tested negative for COVID-19 in the hospital before they left to come here. During an interview on [DATE] at 2:30 PM, Nursing Home Administrator (NHA) A stated, I do not have staffing to take care of positive COVID-19 residents. My staff take care of both 14-day quarantine residents and the other residents on the same assignment. I do not have a designated COVID-19 unit or quarantine unit in this facility. Right now, the 100 hall has isolation rooms that are used for residents that are admitted from the hospital. During an interview on [DATE] at 3:00 PM, Director of Nursing (DON) B stated, Rooms 102, 112, 114, 116, and 128 have isolation residents from the hospital in them for 14-days. During an interview on [DATE] at 2:00 PM, Local Health Department (LHD Epidemiologist I stated, The health department typically waits for the DHHS (Department of Health and Human Services) to notify of positive Covid-19 lab results and is reportable and required to report to the State. COVID-19 is a reportable disease. DHHS did not notified us, the facility called us. I feel the facility did all the appropriate precautions. Within 24 hours there was a nurse assigned solely to the positive case (Resident #104). I talked to (NHA A) and per the facility corporate policy they needed to transfer resident to a HUB or the hospital. I gave her the regional hub list but those facilities not taking residents over the weekend. (NHA A) asked me for a letter stating the facility had exhausted all options and could isolate per CDC guidelines. I am aware of the facility does not have an isolation unit. They created an isolation room for the resident that died . I will not be surprised if the facility gets a few more positive COVID-19 cases pop-up. The only symptoms the resident had was the elevated temperature. There could be a change, the resident comes into contact with COVID-19 anywhere. I don't think if a resident goes out to an appointment or [MEDICAL TREATMENT] they should have to go into isolation for 14-days. During an interview on [DATE] at 9:30 AM with NHA A and DON B, DON B stated, (Resident #110) COVID-19 test results from [DATE] came back positive last night ([DATE]) at around 6:00 PM. He was immediately placed in isolation on the designated COVID-19 hall. After I spoke with the local health department epidemiologist who told me that since (Resident #110) was asymptomatic since [DATE]rd (2020), and it had been 10 days, he longer needed to be kept on transmission-based precautions of contact and droplet isolation. So, at 8 PM last night ([DATE]) (Resident #110) was taken out of isolation. Review of Resident #110's Order Summary Report revealed, .Contact and Droplet Isolation (Transmission-Based Precautions) r/t COVID-19 Active Order Date [DATE] . Observed on [DATE] at 9:40 AM Resident #110 room in the designated COVID-19 area, no isolation cart or signage declaring the resident to be on transmission-based precautions of contact and droplet isolation. Review of email sent on [DATE] at 3:57 PM by NHA A indicated Resident #108 went to theER on [DATE] at 10:40 PM and returned on [DATE] at 4:45 AM. He returned to his previous room with roommate Resident #110. Review of Resident #108's medical records did not reveal documentation he had worn his face covering 100% of the time he was in the hospital. Infection Control Preventionist According to CDC (Centers for Disease Control) at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at high risk of being affected by respiratory pathogens like COVID-19 .As demonstrated by the COVID-19 pandemic, a strong infection prevention and control (IPC) program is critical to protect both residents and healthcare personnel (HCP). Facilities should assign at least one individual with training in IPC to provide on-site management of their COVID-19 prevention and response activities because of the breadth of activities for which an IPC program is responsible, including developing IPC policies and procedures, performing infection surveillance, providing competency-based training of HCP, and auditing adherence to recommended IPC practices . Core Practices These practices should remain in place even as nursing homes resume normal activities. Assign One or More Individuals with Training in Infection Control to Provide On-Site Management of the IPC Program: This should be a full-time role for at least one person in facilities that have more than 100 residents .Smaller facilities should consider staffing the IPC program based on the resident population and facility service needs identified in the facility risk assessment. CDC has created an online training course that can be used to orient individuals to this role in nursing homes. Review of facility policy, Pandemic Episode date undisclosed, revealed, Notification .Facility Coordinator: The facility Infection Preventionist will track and trend reported cases .Local Health Department-The Infection Control nurse will contact local health officials . Review of facility policy, Compliance Monitoring revised ,[DATE], revealed, Policy: To provide a system of monitoring to insure that employees are following established policies regarding Infection Prevention practices. The Infection Preventionist .will establish the methods for compliance monitoring for Infection Prevention . During an interview on [DATE] at 11:35 AM, Director of Nursing (DON) B stated, The facility's certified Infection Control Preventionist (ICP) is (Registered Nurse (RN) V). She has been the ICP since the beginning of March (2020). During an interview on [DATE] at 12:00 PM, DON B stated, I just found out ICP (RN V) is not CDC certified. She has been working with the local health department (LHD) with all the normal transmission-based infections and things the ICP has to do as well as COVID-19. During an interview on [DATE] at 1:55 PM RN V stated, I transitioned into the role as ICP in March (2020). I am not CDC certified. When COVID-19 hit in March (2020) I took over it (COVID-19 infection control) 100%. I do all the infection control for the facility. Review of the facility's staffing description list presented to the surveyor on [DATE] upon survey entrance, revealed that no licensed nursing staff was identified as or assigned as the Infection Control Preventionist.