The Advantage Living Center-Roseville Nursing Home was investigated for a Focused Infection Control Survey and an Abbreviated Survey 03/29/20 through 03/31/20.

Current Census: 95

Intakes: MI00111342

<table>
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<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Pilot</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced To The Appropriate Deficiency)</th>
<th>Completion Date</th>
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</thead>
<tbody>
<tr>
<td>F0000</td>
<td>SS=</td>
<td>INITIAL COMMENTS</td>
<td>The Advantage Living Center-Roseville Nursing Home was investigated for a Focused Infection Control Survey and an Abbreviated Survey 03/29/20 through 03/31/20.</td>
<td>F0000</td>
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<tr>
<td>F0684</td>
<td>SS=G</td>
<td>483.25 Quality of Care</td>
<td>§ 483.25 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents’ choices. This REQUIREMENT is not met as evidenced by:</td>
<td>F0684</td>
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<td></td>
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<td>This Citation Pertains to Intake MI111342 - COVID-19.</td>
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Based on interview and record review, the facility failed to document and implement interventions per Health Care Provider (HCP) order and failed to respond to a change in condition in a timely manner for one (#704) of one Residents reviewed for change in condition resulting in lack of documentation, lack of timely administration of Hypodermoclysis (subcutaneous administration of fluids), and Resident #704 experiencing a change in in condition, severe decline in health condition, and delayed transfer to the hospital related to Covid-19.

Findings include:

On 3/29/20 at 2:30 PM, an interview was conducted with Resident #704's roommate. When queried regarding care including isolation and infection within the facility, the roommate revealed they became ill after (Resident #704) had been ill. With further inquiry, the roommate stated, ""My roommate (Resident #704) was real sick. They got moved (to the isolation unit) on Saturday.""

An interview was conducted with Licensed Practical Nurse (LPN) ""B"" on 3/29/20 at 2:35 PM. When queried regarding Resident #704, LPN ""B"" revealed the Resident was in the hospital but was unsure of the
Resident’s current condition.

Review of Resident #704’s medical record revealed the Resident was originally admitted to the facility on 4/16/13 with diagnoses which included dementia, above the knee amputation, phantom lower extremity pain, dysphagia (difficulty swallowing), and Chronic Obstructive Lung Disease (COPD). Review of the Minimum Data Set (MDS) assessment dated 2/16/20 revealed the Resident was cognitively intact and required supervision to limited assistance to perform Activities of Daily Living (ADLs).

Record review further revealed Resident #704 was transferred to the hospital on 3/22/20 and had not returned to the facility.

Review of Vital Sign Documentation for Resident #704 revealed the following:

-3/22/20 at 8:03 AM: SPO2 89 % on Oxygen via Nasal Cannula
Resident #704's medical record also included the following orders:

-3/20/20 at 3:13 PM: ""Sodium Chloride Solution 0.9%... Inject 50 milliliter (mL)/hour subcutaneously X 24 hours for hypovolemia (decreased fluid/dehydration), anorexia, N/V..."

-3/21/20 at 10:41 AM: ""Oxygen 2L (Liters) NC (Nasal Cannula) continuous for hypoxemia (decreased oxygen in the blood)"

Review of Resident #704’s Medication Administration Record (MAR) revealed documentation of Sodium Chloride Solution on 3/21/20 at 9:00 AM and 12:00 PM.

Review of Resident #704’s medical record revealed the following progress note documentation:
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/16/20</td>
<td>&quot;Health Status Note... Resident... had emesis times one... did complain of coughing with the one emesis...&quot;</td>
</tr>
<tr>
<td>3/16/20</td>
<td>&quot;Nurse Practitioner Note... Reason for visit: Was asked to evaluate resident for c/o (complaints of) N/V (Nausea/Vomiting) ... reports they have been vomiting for last 2 days. (Resident #704) has had no appetite and poor oral intake...&quot;</td>
</tr>
<tr>
<td>3/17/20</td>
<td>&quot;Health Status Note... resident c/o nausea...&quot;</td>
</tr>
<tr>
<td>3/18/20</td>
<td>&quot;Nurse Practitioner Note... Reason for visit: Was asked to evaluate resident for persistent c/o N/V... seen today per nurse request for above complaints. (Resident #704) reports they have been vomiting for last 4 days... has had no appetite and poor oral intake...&quot;</td>
</tr>
<tr>
<td>3/19/20</td>
<td>&quot;Health Status Note... resident not feeling so good today. c/o nausea...&quot;</td>
</tr>
</tbody>
</table>
-3/20/20: "Nurse Practitioner Note... Reason for visit: Was asked to evaluate resident for persistent c/o N/V; AMS (Acute Mental Status change)... Pt (patient) seen today per nurse request for above complaints. (Resident #704) has been vomiting for last 5-6 days... no appetite and poor oral intake... Will order labs to be drawn and start gentle hydration with normal saline... Monitor T (temp), HR (heart rate), SPO2 (pulse ox) closely. Pt is at risk for... Covid19. Will need close monitoring..."

-3/21/20 at 4:52 AM: "Nurses Note... Resident was started on hypodermoclysis Sodium Chloride 0.9 at 50 mL/hr..." (Authored by Nurse "A"")

-3/22/20 at 11:31 AM: "Nurses Note... Resident pulse ox @ 85% on non rebreather mask. Unable to increase oxygenation... Order to transfer resident to (hospital)..."

An interview was conducted with LPN "C" on 3/31/20 at 9:48 AM. When queried if they had cared for Resident #704, LPN "C"
revealed they had. LPN "'C'" further indicated they were assigned to care for the Resident the day they were transferred to the hospital. When queried what occurred the day the Resident was transferred, LPN "'C'" stated, "'Resident #704 wasn't as alert as they normally were. Their oxygen stats were up and down between 80 and 85 percent.'" When asked what actions were taken at the facility, LPN "'C'" detailed, "'I put (Resident #704) on a non-rebreather (oxygen delivery device mask used to deliver high flow oxygen) at 15 liters. (Resident #704) would only go up 85-87% on the non-rebreather.'" LPN "'C'" further revealed the Resident was in the isolation unit of the facility when they were transferred to the hospital and had been in the isolation unit for "'a few days.'" With further inquiry, LPN "'C'" stated, "'(The Resident) had a positive chest X-ray and a cough before they were moved the isolation unit.'" When queried regarding the facility policy/procedures related to be moved/transferred into the isolation unit, LPN "'C'" replied, "'The requirements to move down are cough, hypoxic, X-ray changes, fever.'" When queried if Resident #704 had a temperature documented in the medical record, LPN "'C'" reviewed the record and stated, "'No, I don't see one (elevated temperature) but I know they (facility management/administration) said it was a requirement to move down here (isolation).'" When asked, LPN "'C'" indicated Residents on the isolation unit are confirmed/suspected Covid-19 infection. With further inquiry, LPN "'C'" indicated the Resident may have had a temperature but it might not have gotten documented in the Resident's chart. LPN "'C'" was then asked if Residents who are transferred to the hospital are supposed to have a Transfer or Change of Condition
Assessment documented in the medical record per facility policy/procedure and stated, """"We haven't been doing them (assessments) because they (have) been emergency transfers."""" When asked if they were aware of Resident #704 having a decline or hypoxemia prior to having to be transferred on 3/22/20, LPN """"C"""" stated, """"In report (Nurse """"EE"""") said to watch (Resident #704) because they were worried about them. (Nurse """"EE"""") said (Resident #704) don't look to good."""" With further inquiry, LPN """"C"""" specified that in report, Nurse """"EE"""" revealed Resident #704 was """"on 5 liters of oxygen and they couldn't get them above the high 80's SPO2."""

A phone interview was attempted to be completed with Nurse """"EE"""" on 3/31/20 at 10:40 AM. A voicemail message with return phone number was left.

On 3/31/20 at 10:55 AM, an interview was completed with Resident #704's Family Member """"D"""". When queried regarding Resident #704's care in the facility, Family Member """"D"""" revealed they were informed (Resident #704) had pneumonia by the facility and were sent to the hospital on 3/22/20. Family Member """"D"""" then stated, """"(Resident #704) is on a ventilator now and is in isolation. They (hospital) tested (Resident #704) for Coronavirus and are treating them like they have it."""" With further inquiry regarding the Resident's care in the facility, Family Member """"D"""" stated, """"It's not
A phone interview was attempted to be completed with LPN "E" on 3/31/20 at 11:12 AM. A voicemail message was left with return phone number.

An interview was conducted with LPN "F" on 3/31/20 at 11:15 AM. When asked if they had provided care to Resident # 704, LPN "F" stated, "All I did was document the Covid Assessment." With inquiry regarding their actions when completing the Covid Assessment, LPN "F" replied, "I come in and document the temp. I go to every Resident, take their temp, and put it on their sheet." When asked if they do anything other than take Resident temperatures, LPN "F" stated, "No. If I have any temp, I let the nurse know." When queried if they auscultate Resident lung sounds and documentation of "Lung Assessment" on the Covid-19 assessment in Resident's medical record, LPN "F" stated, "I don't take lung sounds. I know what a wheeze sounds like. If I don't hear anything, I say their lungs are clear." When asked if they are supposed to auscultate lung sounds per facility policy/procedure and how they are able to determine changes in Resident condition without auscultating of lung sounds, LPN "F" replied, "It might be a good idea to do that. No one has said anything to me about it."
An interview was conducted with the Director of Nursing (DON) on 3/31/20 at 11:50 AM. When queried regarding facility policy/procedure and expectations when completing the Lung assessment section of the Covid-19 assessment, the DON stated, ""I expect them (staff) to let me or Infection Control know if there is something changed."" The DON added, ""We actually have a nurse (LPN ''F'') who is coming in just to do the assessments Monday to Saturday."" When queried if the expectation is that nursing staff auscultate lung sounds when completing the Lung assessment section, the DON stated, ""Yes, they are listening to lung sounds."" The interview with LPN ''F'' was discussed with the DON at this time. When queried regarding LPN ''F'' stated they are not auscultating lung sounds the DON replied, ""I was not aware of that. They are supposed to be listening."" The DON was then asked if Nurse ''EE'' and LPN ''E'' were currently working due to being unable to reach them by phone and replied, ""(Nurse ''EE'') is off sick and (LPN ''E'') is in the hospital."" With further inquiry regarding employee illnesses in the facility, the DON revealed the reason for LPN ''E'' being hospitalized and Nurse ''EE'' being off was related to Covid-19. When queried regarding the accuracy of documented assessments when lung sounds were not being auscultated, the DON did not provide further explanation.

An interview was completed with LPN ''A''
on 3/31/20 at 12:00 PM. When queried if they had provided care to Resident #704 on 3/21/20 and if they had initiated the Resident’s NS (Normal Saline) infusion, LPN “A” revealed they worked midnight shift on 3/20/20 into the morning of 3/21/20. LPN “A” stated, “I got there late, probably between 9:00 PM and 10:00 PM.” LPN “A” then stated, “(Resident #704) was in their room with their roommate. The roommate told me (Resident #704) was supposed to be on fluids.” When asked how the roommate was aware of the fluid order but nursing staff was not, LPN “A” stated, “Another nurse confirmed the order but didn’t never start it. I only knew because of the roommate. It didn’t show on the MAR (Medication Administration Record).” LPN “A” further revealed the NS order did show on Resident #704’s orders but had not been done. When queried regarding Resident #704’s condition, LPN “A” stated, “(Resident #704) didn’t look so good. They were gray, kinda pale like.” LPN “A” proceeded to detail, “(Resident #704) had an oxygen tank in their room but it (oxygen) wasn’t on (the Resident) so I put it on.” When queried what the Resident’s oxygen saturation (SPO2) was at that time, LPN “A” replied. “Their oxygen was low. It was 60-70 something (percent). I saw the SPO2 down and I was worried. I put the oxygen on (Resident #704) and it (SPO2) came up to the 80 percent’s.” With further inquiry, LPN “A” then stated, “I was worried, (Resident #704) was dehydrated. Their mouth was so dry, they couldn’t even talk. My main concern was getting the fluids going because that was something that was supposed to have been done.” When asked if they reassessed the Resident during their shift, LPN “A” stated, “I checked (Resident #704) throughout the night. After the fluids
started, (Resident #704) started getting color.''' When asked if they had rechecked the Resident’s oxygen saturation, LPN ‘’‘A’’’ indicated they did and stated, ‘’‘It never got up to 90 (percent).’’’ When asked if they were saying the Residents oxygen saturation remained between 80 to 89 percent on oxygen, LPN ‘’‘A’’’ confirmed that was correct. When queried if the nurse caring for Resident #704 had informed them of any concerns with the Resident when they received report, LPN ‘’‘A’’’ stated, ‘’‘There was no nurse for me to get report from that shift. I had to do rounds and find out stuff on my own.’’’ With further inquiry, LPN ‘’‘A’’’ stated, ‘’‘There may have been a nurse on the other cart, but they weren’t taking care of those people. They couldn’t tell me anything.’’’ When queried if the Resident had a temperature or any other abnormal vital signs during their shift and why no vital signs were documented during their shift, LPN ‘’‘A’’’ stated, ‘’‘No, but (Resident #704) must have (had a temperature) when the lady (LPN ‘’‘F’’’) came in in the morning to do temps.’’’ When queried why they said the Resident must have had a temperature, LPN ‘’‘A’’’ replied, ‘’‘I came back to work that night and (Resident #704) had been moved down to isolation (isolation unit of facility).’’’ When asked why Resident #704’s HCP was not contacted and/or why they were not transferred to a hospital for care due to their change in condition, LPN ‘’‘A’’’ revealed the facility has a protocol in place. With further inquiry regarding the protocol LPN ‘’‘A’’’ stated, ‘’‘We couldn’t send Residents out unless SPO2 is under 80. (Resident #704) was between 80 and 89 (percent) after put on two liters (oxygen).’’’ When queried why they did not document administration of NS in the Medication Administration Record.
(MAR), LPN "'A''' was unable to provide an explanation. When queried why they did not document a note or assessment in Resident #704"s medical record pertaining to the Resident"s condition, LPN "'A''' indicated the facility has been short staffed, they have been very busy, and were concerned with ensuring the Resident"s fluids were started and most likely forgot.

On 3/31/20 at 1:30 PM, a phone call was received from Family Member "'D''' Family Member "'D''' revealed they were calling to provide an update that Resident #704 was being "'taken off the vent today''' due to decline in condition.

A phone interview was attempted to be completed with Nurse "'EE''' on 3/31/20 at 1:54 PM. A second voicemail message with return phone number was left.

A phone interview was attempted to be completed with LPN "'E''' on 3/31/20 at 1:55 PM. A second voicemail message with return phone number was left.

On 3/31/20 at 5:15 PM, an interview was conducted with the ADON (Assistant Director
 When queried regarding Resident #704's normal saline not being initiated when ordered, the ADON reviewed Resident #704's medical record and stated, "I don’t know why. It definitely should have been started." The ADON further revealed the order was "STAT" and "STAT is a four hour turnaround time." When queried regarding LPN "A''s'' statements regarding Resident #704's condition and facility procedure, the ADON was heard reviewing the protocol with the Director of Nursing (DON). The ADON then stated, "The protocol states if the SPO2 is less than 80% or shortness of breath." When queried why Resident #704's change in condition was not identified sooner and why they were not transferred to the hospital sooner, the ADON stated, "I mean, they are taking care of so many people and there are so many people being transferred to the hospital." When queried regarding LPN "A''s'' stating they did not receive report from the nurse working day shift upon arriving to the facility to begin their shift, the ADON stated, "They should have received report."

On 4/2/20 at 9:30 AM, a phone call was received from Family Member "D''. Family Member "D'' revealed Resident #704 had passed away after being removed from the ventilator on 3/31/20. Family Member "D'' further detailed the hospital told them they believed the cause to be Covid-19 but the test results would be reported to them by the Centers for Disease Control (CDC).
Review of facility policy/procedure entitled, ""Acute Change in Condition"" (no date) revealed, ""An Acute Change of Condition (ACOC) is a sudden, clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains. ""Clinically important"" means a deviation that, without intervention, may result in complications or death... Guidelines... 4. Utilize care paths, Document findings, assessments and interventions on the CHANGE OF CONDITION... 5. Changes (symptoms) are communicated to the physician..."

Review of facility policy/procedure entitled, ""Acute Change in Condition"" (no date) revealed, ""An Acute Change of Condition (ACOC) is a sudden, clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains. ""Clinically important"" means a deviation that, without intervention, may result in complications or death... Guidelines... 4. Utilize care paths, Document findings, assessments and interventions on the CHANGE OF CONDITION... 5. Changes (symptoms) are communicated to the physician..."

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<tr>
<th>ID PREFIX TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F0725 SS= F</td>
<td>§483.35(a)(1)(2) Sufficient Nursing Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility’s resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse</td>
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<td>F0725</td>
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to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:

This citation pertains in part to MI00111342.

Based on observation, interview and record review the facility failed to ensure sufficient staffing was present to meet the needs of the residents affecting 41 second floor residents (including R54 and R711) and 31 first floor (one north) residents (including R30) and 23 one south residents resulting in the likelihood of unmet care needs. Findings include:

On 03/29/20 at 6:15 AM, the facility was entered and a COVID (a highly contagious respiratory infection) screening was conducted by the facility staff. Gowns were available in the area, but the screening area was not consistently staffed to ensure compliance with the entry protocol.

On 03/29/20 at 6:55 AM, Certified Nursing Assistant (CNA) """"I"""" was asked about meeting the needs of the residents and reported that they were caring for 31 residents along with the nurse. CNA """"I"""" reported this to be a """"challenge"""" as many residents required assistance including
incontinence care. CNA I also reported that they were the only CNA that came in because of the COVID virus going around and that this was not the first time in the last two weeks.

On 03/29/20 at 7:04 AM, a female resident on the unit of CNA I was observed to be restless in bed, wearing only a brief. The resident was observed with foam boots around their feet and moving their legs in and out of the bed. At one point the resident had raised their legs to rest on the over bed table along the right side of the bed.

On 03/29/20 at 7:15 AM, second floor nurse LPN L was asked about COVID training and staffing. LPN L reported that there were supposed to be at least two aides and two nurses on the floor and that the facility schedules people, but they don’t show up so “Sometimes it is really bad.” LPN L then reported they had to care for 41 residents over night and that is why they were still trying to complete their medication pass. It was observed that the medications were highlighted in red on the computer to indicate they were late.

A review of the nurse/CNA schedule dated 03/28/20 (Saturday) for the 11:00 PM to 7:15 AM shift revealed one CNA was a NCNS (no
Eight of eight scheduled CNAs failed to show for work. For the afternoon/night 7:00 PM to 7:30 AM shift one of four nurses scheduled came to work. Two nurses were added to account for one nurse for the second floor, one nurse for one south and one nurse for one north observed. Five of ten scheduled CNAs for the 3:00 PM to 11:15 PM shift appeared for work. One of the five was not confirmed by a facility timecard. The rest were confirmed with the timecards provided.

A review of the nurse/CNA schedule dated 03/29/20 (Sunday) for the 11:00 PM to 7:15 AM shift revealed two of seven CNAs appeared for work. This left one CNA for the reported 41 residents on the second floor and one CNA for the reported 31 residents on one North and one CNA for the reported 23 residents on one South (isolation unit). A review of the nursing schedule for 03/22/20 revealed for the evening shift (3:00 PM to 11:15 PM) three of nine scheduled CNAs appeared for work. These were also confirmed with the facility timecards.

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<th>ID PREFIX</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
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</table>
| call no show) and five CNAs were marked as WNBI (will not be in). This left one CNA for the reported 41 residents on the second floor and one CNA for the reported 31 residents on one North and one CNA for the reported 23 residents on one South (isolation unit). Six of eight scheduled CNAs failed to show for work. For the afternoon/night 7:00 PM to 7:30 AM shift one of four nurses scheduled came to work. Two nurses were added to account for one nurse for the second floor, one nurse for one north and one nurse for one south observed. Five of ten scheduled CNAs for the 3:00 PM to 11:15 PM shift appeared for work. One of the five was not confirmed by a facility timecard. The rest were confirmed with the timecards provided.

A review of the nurse/CNA schedule dated 03/29/20 (Sunday) for the 11:00 PM to 7:15 AM shift revealed two of seven CNAs appeared for work. This left one CNA for the reported 41 residents on the second floor and the reported 31 residents on one North and one CNA for the reported 23 residents on one South (isolation unit). Four nurses appeared for the night shift (7 PM to 7:30 AM). Two were indicated to have worked on the second floor, one for one south and one possibly for one north. For the afternoon shift (3:00 PM to 11:15 PM) three of nine scheduled CNAs appeared for work. These were also confirmed with the facility timecards.

A review of the nursing schedule for 03/22/20
(Sunday) for the 11:00 PM to 7:15 AM shift revealed three nurses and three aides appeared for work per the facility time card. The names of the DON and ADON were written in on the schedule but a time card was not received.

On 03/29/20 at 7:25 AM, CNA "M" was asked about their ability to meet the needs of 41 residents and stated, "It feels horrible." CNA "M" reported they were able to get to 23 of the 41 residents over night and was still working to get them done as three CNAs were scheduled but only they (CNA "M") showed up. CNA "M" also reported they had to change the linens on a few of them due to multiple incontinence episodes.

On 03/29/20 at 7:30 AM, CNA "M", CNA "N" and CNA "P" were asked about staffing during the COVID outbreak and all agreed it was a challenge and hard to get staff to show up for work. The CNAs also noted three residents had been sent out to the isolation unit or the hospital with symptoms of COVID and one had died. They did report that four CNAs and two nurses were normally used on the floor during the day shift due to the number of dependant residents.

On 03/29/20 at 7:45 AM, CNA "P" was
<table>
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<th>Event Date</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>03/29/20</td>
<td>Nurse &quot;&quot;Q&quot;&quot; reported that on the weekend the floor nurse completes the wound care on the residents and they were the only nurse to come in for the floor so far.</td>
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<tr>
<td>03/29/20</td>
<td>Nurse &quot;&quot;U&quot;&quot; reported they had been pulled from the first floor and a manager (In-service Director) took their cart.</td>
</tr>
<tr>
<td>03/29/20</td>
<td>Wound Nurse &quot;&quot;R&quot;&quot; was asked about staffing and meeting the needs of the resident and stated, &quot;&quot;We are trying to manage.&quot;&quot;</td>
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<tr>
<td>03/29/20</td>
<td>R54 was observed in bed, uncovered, undressed and wearing only a brief.</td>
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On 03/29/20 at 11:16 AM, R30 was asked about care during the COVID outbreak and reported, they were not receiving their baths or showers and wanted to get out of their room at least for a little while. R30 indicated no staff would let them go out of their room as someone would need to be with them.

On 03/29/20 at 11:24 AM, CNA "'T'" was asked about meeting the needs of residents and reported they had two CNAs to care for 31 residents on the day shift and there were three sometimes. CNA "'T'" reported having two CNAs as "'challenging.'"

A review of the record for R711 revealed the last documentation for the Activities of Daily Living (ADL) bathing task as of 03/31/20 was on 03/19/20. A review of the bowel and bladder elimination task revealed R711 to be incontinent of bowel and bladder. The Care Plan revealed: "'I am at increase risk for alteration in psychological/social well being due to visitation and social restrictions related to COVID-19. Date Initiated: 03/15/2020; I am incontinent of Bowel and/or Bladder Impaired Cognition, Weakness, Dementia: Check me at least every two hours during the day and change my brief if needed."
Date Initiated: 05/12/2016. I require 24/7 supervision and assistance with ADL’s. My transfer status: Total Hoyer with two person assist. Bathing/Showering: I am totally dependent on you to give me a bath / shower at least twice weekly and as necessary. Wednesday and Saturday afternoon shift

Date Initiated: 05/03/2016.

On 03/31/20 at 2:25 PM, the Director of Nursing was asked about staffing on the night shift being at one nurse and one CNA to 31 or 41 residents. The DON reported that staffing at one staff to 15 residents was acceptable as a minimum, but preferred it to be 1:8 on all shifts. The DON reported the staffing was low because of call offs.

A review of the facility "Staffing Schedule Review (undated)" revealed, "The purpose of reviewing the staff schedule is to assure the facility has adequate staffing each day and to anticipate the following day (weekend) staffing that may need to be addressed to avoid a staffing crisis."

F0880  483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection
Prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§ 483.80 (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

1. A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to § 483.70(e) and following accepted national standards;

2. Written standards, policies, and procedures for the program, which must include, but are not limited to:
   - A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
   - When and to whom possible incidents of communicable disease or infections should be reported;
   - Standard and transmission-based precautions to be followed to prevent spread of infections;
   - When and how isolation should be used for a resident; including but not limited to:
     - The type and duration of the isolation, depending upon the infectious agent or organism involved, and
     - A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
   - The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

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Hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:

This Citation Pertains to Intake MI111342-COVID-19

Based on observation, interview, and record review, the facility failed to institute and operationalize appropriate infection control principles and practices per the Centers for Disease Control (CDC) guidance and failed to provide care and assessment per professional standards of practice for care of Residents with confirmed and suspected Covid-19 (a highly contagious severe respiratory infection) for 23 Residents (including Resident #’s 11, 20, 21, 28, 34, 65, 67, 91, 703, 704, 705, 706, 707, 708, and nonsampled Resident #’s 1, 2, 3 and 4) housed on the designed isolation unit of the facility. This deficient practice resulted in lack of appropriate application, utilization, and disposal of Personal Protection Equipment (PPE), lack of assessment per nursing professional standards of practice, lack of facility provided and dedicated medical equipment for Residents on isolation.
precautions, lack of adequate disinfection and cleaning procedures, cross
contamination between the isolation unit and
non-isolation areas of the facility, ongoing
Resident infections including two Residents
(#701 and 702) being transferred to the
Isolation Unit on 3/29/20, nine Resident
deaths with confirmed/suspected Covid-19
infection and the likelihood of infection and/or
death for all 95 Residents residing in the
facility.

The Immediate Jeopardy (IJ) started on
3/12/20 and was identified on 3/29/20.

The Administrator was notified of the
Immediate Jeopardy on 3/29/20 and was
asked for a plan to remove the immediacy.

The IJ was removed on 3/29/20, based on
the facility’s implementation of the removal
plan as verified onsite on 3/29/20.

Although the immediacy was removed the
facility’s deficient practice was not corrected
and remained widespread with actual harm
that is not immediate jeopardy.
Findings include:

Record revealed, since 3/12/20, the infection rate within the facility increased exponentially with 19 Residents being sent to the hospital as Persons Under Investigation (PUI- person who has both consistent signs or symptoms and risk factors of infection without available testing for infection confirmation) with Covid-19 symptoms, two confirmed deaths related to Covid-19 and seven additional Resident deaths for Residents considered PUI. Review further reviewed twenty-three PUI Residents with symptoms of Covid-19, including one confirmed Resident with Covid-19, remained in the facility on the isolation unit.

Upon entering the facility at 6:15 AM on 3/29/20, Licensed Practical Nurse (LPN) "A" was observed exiting the Resident care area of the facility, through a closed door, and entering the lobby of the facility wearing a blue colored, long sleeve PPE gown. LPN "A" did not remove the gown and/or perform hand hygiene prior to exiting the Resident care area of the facility. An interview was completed with LPN "A" at this time. When queried regarding Covid-19 infection within the facility, LPN "A" revealed the One South Unit was being utilized as an isolation unit for Residents with positive or suspected Covid-19 infection. LPN "A" completed the facility Covid-19
screening and recorded a temporal (forehead) temperature (for this surveyor) of 80.3 degrees Fahrenheit (F- Normal body temperature range is 97.0 F to 99.0 F). The temperature recording was not immediately retested to ensure accuracy of the thermometer. LPN "A" was then observed reentering the Resident care area of the facility in the same blue colored PPE gown without doffing (removing) or donning (applying) new PPE. Cloth, hospital style gowns (short sleeved with snap arms) were available in the lobby area of the facility and provided as PPE to individuals entering the facility. However, the lobby/screening area was not consistently staffed and staff were observed entering the main facility door utilizing their employee badge.

On 3/29/20 at 6:20 AM, an observation occurred of the One-South unit of the facility. The unit entrance doors were closed with a sign in place which indicated PPE including gown, head protection, eye protection, gloves, and mask were required for entry. However, no PPE and/or method to perform hand hygiene were present near the entry doors to the unit and there were no staff present in the area outside of the isolation unit doors. Upon entering the unit, PPE and/or a method to perform hand hygiene was not present near the entrance of the unit. A tour of the unit at this time revealed the doors to all Resident rooms were open. Several rooms had two Residents in the room. The Residents were noted to be less than six feet apart from each other in bed and the curtains between the Residents were open. Resident #65 and Resident #91 did not
have a curtain in their room. A pole and pump for intravenous (IV) medication administration was observed in the hall of the facility directly outside of an occupied Resident room. The IV pump had IV medication hung on the pole with the medication administration tubing connected and fed through the IV pump. The medication was labeled for administration to an unknown Resident. Two staff were present on the unit, LPN "A" and Nursing Assistant "G". LPN "A" was wearing a blue colored, long sleeve PPE gown and mask. Nursing Assistant "G" had a cloth hospital style gown over their scrubs and a mask. Both Nursing Assistant "G" and LPN "A"s" masks were not positioned properly on their heads/faces and neither staff member were wearing eye protection.

An interview was conducted with LPN "A" on 3/29/20 at 6:30 AM. When queried if they were wearing the same PPE gown they wore when they entered the facility lobby, LPN "A" replied, "Yes." When queried why they did not remove their gown prior to exiting the isolation unit and Resident care area of the facility, LPN "A" stated, "We were told we can leave it on our whole shift and change gloves." When asked how many Residents were on the isolation unit, LPN "A" replied, "Have 23 now." LPN "A" further revealed additional Residents were transferred to the isolation unit from other areas of the facility during the night. When asked which Residents were transferred to the unit during the night, LPN "A" revealed Resident #701 and Resident #702. When asked how many staff were
present on the unit, LPN ""A"" replied, ""Only me and a CNA (Nursing Assistant) down here all night."" With further inquiry, LPN ""A"" stated, ""I can't even take a break, these patients are critical."" When asked how many of the Residents had been diagnosed with Covid-19, LPN ""A"" revealed they were only aware of one Resident who had tested positive (Resident #1) and stated, ""They told me these people (Residents) are all pneumonia but it is not like I have time to look up medical information."" LPN ""A"" further revealed the facility was unable to obtain tests for the virus and stated, ""There are no tests."" When asked, LPN ""A"" indicated the unit was considered the ""Covid Unit"" and Residents with Covid-19 symptoms were placed in the unit. LPN ""A"" was queried if they were always assigned to work in the isolation unit of the facility and replied, ""No. This is my second time working down here."" When asked what symptoms the Residents on the unit were displaying, LPN ""A"" replied, ""Loss of smell/taste, diarrhea, shortness of breath, hypoxia (decreased blood oxygen level), fever."" When queried regarding Resident assessments and if any Residents had fevers, LPN ""A"" stated, ""Pretty much everyone."" LPN ""A"" was then observed touching their face and then preparing medications for administration to a Resident. When asked if any Residents were having trouble breathing, LPN ""A"" indicated there was and revealed they had a portable finger pulse oximeter to assess Resident oxygen levels. Two portable pulse oximeters were observed on the medication cart. One pulse oximeter was pink in color and the other was yellow. The yellow colored pulse oximeter did not have a plastic piece covering the batteries of the pulse oximeter and the
batteries were noted to be exposed and secured in the device with tape. A wrist style blood pressure monitoring device was also noted on the medication cart. When queried regarding the pulse oximeters and wrist blood pressure cuff, LPN "'A'" revealed they were their personal devices. When asked if the facility had automatic vital sign monitoring machines, LPN "'A'" replied, "'No.'" With further inquiry regarding the use of personal monitoring items for Resident care and facility provision of equipment necessary for Resident care, LPN "'A'" stated, "'Sometimes you gotta spend your own money to make your day go okay.'" When queried regarding the location of PPE for staff working on the isolation unit and where they had obtained the blue gown they were wearing, LPN "'A'" stated, "'It was here when I got here but there were only two (gowns available).'' When queried regarding eye protection, including a face shield or goggles, LPN "'A'" stated, "'We don't really have face shields. There are a couple pair of goggles, but they slide right off my face.'" When asked if any Residents on the isolation unit were receiving breathing treatments, LPN "'A'" replied, "'Yes.'" When queried if they were aware their mask was not positioned properly and was not fitted across the bridge of their nose, LPN "'A'" replied, "'No.'" LPN "'A'" then stated, "'I have one (Resident) who is actively dying right now.'" When asked about the Resident, LPN "'A'" replied, "'They are a DNR (Do Not Resuscitate) but not hospice.'"

On 3/29/20 at 6:45 AM, an interview was completed with Nursing Assistant "'G'".
When queried regarding their assignment, Nursing Assistant "'G'" revealed they were the only Nursing Assistant working on the isolation unit of the facility and had 23 Residents. Nursing Assistant "'G'" further revealed there was no housekeeping or other staff present on the unit to assist on midnight shift. When queried how many Residents on the unit required assistance and/or were incontinent, Nursing Assistant "'G'" replied, "'98%.'" Nursing Assistant "'G'" was asked how they are able to provide care to each Resident every two hours and stated, "'I can't.'" Nursing Assistant "'G'" further revealed they do their best but must prioritize which Resident needs to be changed the most. When queried regarding the IV pole and medication outside of a Resident room, Nursing Assistant "'G'" looked at the name of the Resident on the IV medication bag in the hall and stated, "'Oh, that Resident was transferred to the hospital.'" Nursing Assistant "'G'" was asked when the Resident was transferred, and replied, "'I think a week or so ago.'" When asked why they were wearing a hospital gown over their scrubs, Nursing Assistant "'G'" revealed that was what they had been provided as PPE by the facility. With further inquiry regarding PPE and if they were provided a blue gown, like LPN "'A'" was wearing, Nursing Assistant "'G'" stated, "'Only gave a hospital gown.'" When asked if they were provided and/or had eye protection available for PPE, Nursing Assistant "'G'" replied, "'No.'" When queried if they received education regarding how to properly don, wear, and doff their mask, Nursing Assistant "'G'" stated, "'Not recently.'" When queried if they are in close proximity to Residents when they are coughing and if the Residents breathe on them during care, Nursing Assistant "'G'"
replied, "Absolutely."

At 6:50 AM on 3/29/20, Resident #701 was observed in their room with the door of the room open to the hall. The Resident was wearing only a disposable brief and was visible from the hall of the facility. The Resident’s legs were off the bed, with their bare feet on the floor. They were not speaking but appeared to be reaching for something on the floor. Nothing was visible on the floor. Nursing Assistant "G" was observed entering the room at this time. Nursing Assistant "G" touched the Resident and multiple items in the room without gloves before applying gloves.

An interview was conducted with Housekeeping Staff "X" on 3/29/20 at 7:00 AM. When queried, Housekeeping Staff "X" revealed they were assigned to clean the isolation unit of the facility. When asked what products they were using to clean, Housekeeping Staff "X" revealed they were cleaning with "Peroxide with multi surface cleaner and disinfectant spray." When queried what items are cleaned in Resident rooms, Housekeeping Staff "X" replied, "Wipe down the toilet, sink, doorknobs, bed side table, call light, side rail." When queried what the floors are cleaned with, Housekeeping Staff "X" replied, "The regular floor cleaner." Housekeeping Staff "X" was queried if the process for cleaning rooms when a Resident is discharged from the facility is different and stated, "Spray the
### Statement of Deficiencies and Plan of Correction

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<tr>
<th>(X4) ID</th>
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<th>ID</th>
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<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>(X5) Completion Date</th>
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<td>whole room with the cleaner and let it sit for five minutes.**</td>
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On 3/29/20 at 7:13 AM, Housekeeper ""K"" was asked about training related to cleaning for the COVID virus and reported a gown and mask were to be worn while in the facility. The gown worn by Staff ""K"" was noted to be untied in the back and hung loosely at their sides. Housekeeper ""K"" further revealed their mask was to be worn for thirty days and they placed it into a ""Ziplock"" bag when leaving work for the day.

On 03/29/20 at 7:20 AM and at 11:45 AM, the two south shower room toilet area was observed to have a bed sheet, a toilet brush laying on its side, two crumpled paper towels, and a crumpled disposable glove scattered around the floor. Two large black combs rested on the sink counter and a piece of clothing hung off the back of a shower chair.

An interview and observation of the isolation unit of the facility was conducted with the Assistant Director of Nursing (ADON) who also functions as the facility infection control nurse on 3/29/20 at 7:20 AM. When queried regarding facility policy/procedure and expectations regarding PPE for staff upon exiting the unit, the ADON indicated PPE...
should be removed and hand hygiene should be performed. When queried where staff are to place removed PPE and perform hand hygiene, the ADON stated, ""There should be a container there (at unit exit)."" When asked why there was not a PPE disposal container, the ADON indicated they were not sure where the disposal containers had gone. When asked about hand hygiene, the ADON indicated staff would be able to wash their hands in a Resident room or the soiled utility room. When queried if those areas were upon exiting the unit, the ADON stated, ""No."" A tour of the unit was conducted with the ADON at this time. All the hall doors to occupied and unoccupied Resident rooms remained opened. When queried if the doors are supposed to be closed per facility policy/procedure, the ADON replied, ""Yes."" When queried regarding staff utilization of personal wrist blood pressure monitors, thermometers, and pulse oximeters for Resident care, the ADON indicated they were not aware staff were using personal monitoring devices for Resident care. When queried regarding reports that an automated vital sign monitoring device was not available in the facility, the ADON stated, ""We don't have one."" The ADON further revealed obtaining automated vital sign monitoring devices was ""something they had been working on."" When queried regarding facility staffing in the isolation unit, the ADON stated, ""I worked all night in the other unit"" due to staffing concerns. No further explanation was provided. When asked about dedicated monitoring equipment in Resident rooms who are on isolation, the ADON revealed a blood pressure cuff and equipment should be present in each Resident room in the isolation unit.
On 3/29/20 at 7:37 AM, an interview was completed with Licensed Practical Nurse (LPN) "B". When queried, LPN "B" revealed they were assigned to work on the unit for day shift and that this weekend was the first time they worked on the isolation unit. When queried who and how many Nursing Assistants were assigned to work on the unit for day shift, LPN "B" replied, "I don't know, probably one." When queried how Resident vital signs are obtained and if there are blood pressure cuffs in each Resident room, LPN "B" stated, "No, I have my own." LPN "B" was then observed removing a wrist style blood pressure monitoring device, a thermometer, and a portable finger pulse oximeter from a cloth bag on top of the medication cart. When asked if the facility provided equipment for monitoring and assessing Resident condition, LPN "B" revealed the facility did not have vital sign monitoring equipment and they purchased their own. When asked if they used the items for multiple Residents, LPN "B" indicated they did. When queried how they cleaned the items between use on different Residents, LPN "B" revealed they use alcohol from home and produced an unmarked, colored spray bottle from a different bag at the nurses’ station containing a liquid. With further inquiry, LPN "B" stated they, "Filled it (spray bottle) with a bottle from home." When queried regarding facility policy/procedure pertaining to cleaning medical equipment utilized in Resident care, LPN "B" did not provide an explanation.
On 03/29/20 at 7:45 AM, Nursing Assistant "P", Nursing Assistant "M" and Nursing Assistant "N" were asked about residents who had recently transferred to the isolation unit and reported Resident #67 had "A couple of days ago." Resident #67 was transferred into isolation on 3/27/20 with a fever and cough. Resident #711 was in the room next door and was transferred into isolation on 3/27/20 with a fever and cough. Resident #711 was the room next door and was transferred into isolation on 3/31/20.

A review of the record for Resident #711 revealed: Resident #711 was admitted into the facility on 9/30/19. Diagnoses included, Dementia, Anxiety and Cancer. COVID 19 assessments for Resident #711 from 3/17/20 to 3/31/20 documented no fever, cough or congestion. A review of the Nurse Practitioner (NP) note dated 3/31/20 revealed: "Reason for Visit: PNA (pneumonia); high rate of COVID 19 exposure in facility. Pt (Patient) was noted to have increased cough with copious secretions (congestion) and hypoxemia (low oxygen/shortness of breath) over the weekend, left eye opaque, yellow crusts to lid margins, will start Azithromycin (antibiotic) and transfer to isolation unit. High rate of exposure of COVID 19 in facility." A nurse progress note dated "3/29/2020, 2:22 PM, resident observed choking on secretions. Vitals are as follows: BP (blood pressure) 157/118... Spo2 87% (oxygen saturation) assessment findings: audible crackles in both lungs." These notes contradict the COVID assessment findings.
On 3/29/20 at 7:50 AM, Nursing Assistant "H" was observed standing in the hall of the isolation unit, wearing a hospital gown over their scrubs, near a food tray delivery cart. Nursing Assistant "H" was not wearing eye protection. An interview was conducted at this time. When asked if they were the assigned Nursing Assistant for the isolation unit on day shift, Nursing Assistant "H" stated, "No. There is no CNA down here."

Nursing Assistant "H" was asked if they had ever worked on the isolation unit and replied, "No. I'm just down here to pass trays."

Nursing Assistant "H" was then observed removing a food tray from the cart and entering Resident #95's room. Nursing Assistant "H" did not have gloves on and touched the Resident's bedding and overbed table. Nursing Assistant "H" then exited the room without performing hand hygiene and returned to the food tray cart in the hall. Nursing Assistant "H" obtained another tray from the cart and entered Resident #28's room. Nursing Assistant "H" moved the Resident's personal items on the overbed table, placed the tray on the table, touched the Resident's bed controller, adjusted the Resident in bed, and opened items on the Resident's food tray without wearing gloves. Nursing Assistant "H" then exited the room without performing hand hygiene, walked down the hall to the food tray cart, and obtained another food tray. Nursing Assistant "H" then entered and exited Resident #5 and Resident #11's room with the tray, did not provide the tray to either Resident, and placed the tray back in the food tray cart. Nursing Assistant "H" proceeded to obtain another food tray and entered Resident...
#34’s room. Nursing Assistant ""H"" was observed touching multiple items in the Resident’s room including the light switch, the overbed table, the bed, and the bed controller. Nursing Assistant ""H"" opened items on the Resident’s tray and exited the room without performing hand hygiene. As Nursing Assistant ""H"" was walking back to the food tray cart, they were observed touching their face.

On 3/29/20 at 8:06 AM, Housekeeper ""Y"" was observed not wearing the required gown while on the second floor.

At 8:10 AM on 3/29/20, an observation of vital sign measurement occurred with LPN ""B"" for Resident #21. LPN ""B"" took their personal wrist blood pressure monitor and pulse oximeter into the Residents room. When asked how they were feeling, Resident #21 stated, ""I don’t feel good. I’m coughing and I feel like I’m going to throw up."" LPN ""B"" obtained the Resident’s blood pressure at this time. They placed the cuff over the Resident’s wrist but did not raise the Resident’s arm and wrist to the level of their heart. LPN ""B"" did not obtain the Resident’s temperature while in the room. LPN ""B"" then removed the wrist blood pressure monitor and placed it directly on the Resident’s overbed table. When asked if the Resident had a dedicated, disposable blood pressure cuff and thermometer in their room, LPN ""B"" revealed they were not aware of any Residents having dedicated, disposable
equipment. LPN "B" then looked in the Resident's room and stated, "No, nowhere." Then exited the room carrying the wrist blood pressure monitor and pulse oximeter. LPN "B" placed the equipment directly on the medication cart, where medications are prepared, prior to cleaning the equipment by spraying it with the unknown substance in the unlabeled spray bottle they previously revealed they had brought from home.

An interview was conducted with LPN "A" and LPN "B" on 3/29/20 at 8:15 AM. When queried if the room divider curtains were supposed to be pulled between Residents sharing a room, LPN "A" stated, "Yes." When queried regarding Resident #65 and Resident #91 not having a curtain in their room, LPN "A" indicated they were not sure why there was not a curtain in the room. When queried if the hall doors to the Resident rooms were supposed to be shut on the isolation unit, LPN "B" stated, "Not made aware if supposed to. We can't see the Residents if we are supposed to." A cloth bag was observed sitting on the nurses' station counter. When queried regarding the bag, LPN "A" revealed it was their bag. When asked if they were supposed to bring personal items on the isolation unit, per facility policy/procedure, LPN "A" stated, "They (facility management/administration) haven't said anything." At this time, LPN "A" and LPN "B" were queried regarding the IV pole and medication outside a Resident's room. LPN "A" revealed the Resident the medication was for had been transferred to the hospital.
On 3/29/20 at 8:20 AM, After passing trays to multiple other rooms, without wearing gloves or performing hand hygiene, Nursing Assistant ""H"" was observed exiting the isolation unit, without performing hand hygiene and without removing the hospital gown they wore within the isolation unit as PPE.

An interview was conducted with Nursing Assistant ""Z"" and Nursing Assistant ""AA"" on 3/29/20 at 8:22 AM. Both staff were observed in the hall of the isolation unit wearing hospital gowns over their scrubs and without eye protection. When queried regarding PPE and the cloth hospital gown they were wearing over their scrubs, Nursing Assistant ""Z"" stated, ""That’s all they gave me"" and Nursing Assistant ""AA"" nodded their head in agreement. When queried regarding eye protection, Nursing Assistant ""Z"" revealed there were goggles available somewhere on the unit and Nursing Assistant ""AA"" stated they ""didn’t know"" about eye protection. When queried where PPE is supposed to be placed upon exiting the unit, Nursing Assistant ""Z"" walked to the isolation unit exit doors and indicated there was nowhere to place PPE after removal. When asked where they removed PPE when exiting the unit, Nursing Assistant ""Z"" did not provide a response. When queried where they obtained the hospital gown being used as PPE, Nursing Assistant ""Z"" indicated they got the gown in the lobby when they first

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<th>ID PREFIX TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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Event ID: BDL911  Facility ID: 504180
arrived at the facility for work.

On 3/29/20 at 11:13 AM, CNA "S" was asked about the care of Resident #702 and reported the Resident had been transferred to the COVID isolation unit due to a rough, dry cough. CNA "S" did not recall what PPE was in use at the time of transfer.

On 3/29/20 at 11:15 AM, a tour of the one north unit was completed. Resident #701's name was present outside of the door of the room and the Resident's bed was observed with no sheets and/or bedding in place on the mattress. The room was shared with Resident #701 and Resident #20. Resident #20 was observed in their room in bed with only undergarments on. An interview was conducted at this time. When asked how they were feeling, Resident #20 stated, "I'm so hot." When queried regarding if they were feeling sick, Resident #20 indicated they just felt "so hot." When asked if their roommate had been ill, Resident #20 revealed they had.

An interview was conducted with LPN "BB" on 3/29/20 at 11:20 AM. When queried regarding Resident #20 stating they felt hot and their roommate recently being transferred to the isolation unit as a PUI for Covid-19, LPN "BB" indicated Resident #20...
is frequently hot. When queried regarding the Resident’s temperature, LPN "BB" obtained a thermometer from a bag on top of the medication cart. When asked if the thermometer was provided by the facility, LPN "BB" stated, "No, I always use my own." When asked if the facility provided equipment to obtain Resident vital sign measurements, LPN "BB" indicated they needed to use their own due to the lack of availability of equipment and working equipment at the facility.

On 3/29/20 at 11:30 AM, Housekeeper "O" was asked when they had received their training on cleaning for COVID and stated, "Two days ago." Housekeeper "O" noted they had been working during the outbreak, but not on the isolation unit. Housekeeper "O" reported the use of a "Peroxide Multi Surface Cleaner and Disinfectant" for all cleaning activity. Housekeeper "O" did not know how long the dwell time (time to disinfect) for the disinfectant was as they reported the cleaner was sprayed on and wiped off (immediately). The product details for the cleaner indicated a three to five minute dwell time for the Flu and other germs and as fast as 45 seconds for Norovirus.

An interview was conducted with the ADON on 3/29/20 at 12:15 PM. When queried how facility nursing staff know which Residents should be placed in the isolation unit of the facility, the ADON replied, "We have a protocol from the Doctor." When queried...
regarding staff use of personal vital sign monitoring equipment including reliability of equipment and results, the ADON indicated staff are supposed to use facility equipment and stated, ""I would like something standard."" The ADON was then queried regarding observation of staff personal items/bags on the counter of the nurses" station in the isolation unit and stated, ""(Staff) stuff should be in their lockers, gonna be getting themselves sick."" When queried regarding facility policy/procedure related to cleaning equipment after use, the ADON indicated cleaning solutions were available for staff to use. When asked about LPN ""B"" bringing a bottle of unknown and unlabeled solution from home to clean their personal devices used to obtain Resident vital signs, the ADON stated, ""No. It will be gone."" When queried regarding infection control tracking and mapping of infections, the ADON stated, ""With everything that has been going on, I honestly haven"t had a chance to really get to it."" When asked if they had identified any trends in the areas of Covid-19 infection within the building including commonalities and/or illnesses among staff, the ADON indicated they had not noted the infection to be in any specific area of the building. All completed infection control data including line listing and mapping information were requested at this time.

On 3/29/20 at 1:58 PM, the IV pole and pump with medication labeled for a discharged Resident remained in the same place in the hall of the facility and all Resident room doors remained open.
At 2:00 PM on 3/29/20, coughing could be heard in the hall from Resident #702’s room. The door to the room from the hallway was open. Upon knocking and entering the room, the Resident was observed in bed. The Resident was receiving oxygen via nasal cannula by means of a portable oxygen tank. An interview was conducted with the Resident at this time. When asked how they were feeling, Resident #702 stated, "I need cough medicine and something for pain." Resident #702 was asked when they were moved into their current room on the isolation unit and indicated the prior night. When asked how long they had been coughing, Resident #702 revealed they were unsure of the date. When asked if they had been coughing as much as they are now when in their other room in the facility, Resident #702 stated, "Yeah, I was."

Review of Resident #702’s medical record revealed the Resident was admitted to the facility on 3/11/20 with diagnoses which included Congestive Heart Failure (CHF), chronic kidney failure, sixth nerve palsy affecting the right eye, and upper respiratory infection. Review of the Minimum Data Set (MDS) assessment dated 3/16/20 revealed the Resident was cognitively intact and required supervision to extensive assistance to perform Activities of Daily Living (ADLs). Review of facility provided documentation revealed the Resident was transferred to the isolation unit of the facility on 3/29/20.
Review of Resident #702’s progress note documentation in the medical record revealed the following:

-3/18/20: """"Nurse Practitioner (NP) Note...
Reason for Visit: worsening cough x 1 day...
RR (Respiratory Rate) regular &amp; unlabored, mild expiratory wheezing... NP (Non-Productive) cough...reports worsening cough today... hypoxemia (abnormally low concentration of oxygen in the blood) reported, no SOB (Shortness of Breath) ... monitor VS (Vital Signs) daily. Order placed... Check CXR (Chest X-Ray) if no improvement...""

-3/25/20: """"Nurses Note... Resident... lying in bed at a high fowler position (sitting upright) resident C/O (Complain Of) persistent dry cough..."

-3/26/20: """"Respiratory Therapy Note...admits to cough, lung sounds with course air entry...""
-3/26/20: "**Nurse Practitioner Note... Reason for Visit: persistent cough x 1 week... lung sounds diminished... Cough... Check CXR, (laboratory testing)... Monitor T (Temperature), HR (Heart Rate), SPO2 (blood oxygen level) closely. Discussed with nurse...**"

Review of Resident #702’s Chest X-Ray results, dated 3/26/20, revealed,

"**Impressions: Minimal left lower lung zone linear atelectasis (lung collapse or closure with no air exchange) noted...**"

Resident #702’s vital sign documentation revealed the Residents blood oxygen level (SPO2) was 89% (normal range greater than 92% on room air) with oxygen via nasal cannula on 3/29/20 at 7:12 PM. Review further revealed the Resident had never received oxygen therapy while at the facility and their SPO2 level previously ranged from 93 to 98% on room air.

On 3/29/20 at 2:10 PM, Resident #701 was observed in their room in the facility with their eyes closed. The Resident’s room door was open, the Resident was uncovered in bed, and wearing only a disposable brief.
Review of Resident #701’s medical record revealed the Resident was admitted to the facility on 1/14/20 with diagnoses which included diabetes mellitus, Cerebral Vascular Accident (CVA- Stroke) with resulting right sided hemiplegia and hemiparesis (one sided paralysis), dysphagia (difficulty swallowing) and convulsions. Review of the Minimum Data Set (MDS) assessment dated 1/21/20 revealed the Resident was cognitively intact and required supervision to extensive assistance to perform Activities of Daily Living (ADLs). Review further revealed the Resident was transferred to the facility isolation unit on 3/28/20 from the one north unit of the facility due to symptoms of Covid-19.

Further review of Resident #701’s medical record documentation revealed a “’Nurse Practitioner Note’’ dated 3/26/20 detailing, “’SPO2 decreased from baseline and c/o (complain of) CP (Chest Pain) ...will check cxr (chest X-ray), labs. SPO2 is trending down. Monitor T (temperature), HR (heart rate), SPO2 2x shift...’’

On 3/29/20 at 2:20 PM, The door to Resident #65’s room was open, and the Resident was visible from the hall of the facility. The Resident’s face was flushed, dark red in color and visibly different from previous observations. The Resident did not respond to knocking on the door or saying their name. LPN “B” was at the medication cart at this time and queried regarding the Resident. LPN “B” was observed entering Resident #65’s room at this time. LPN “B” touched the Resident’s forehead and stated, “Oh they warm.” LPN “B” then used their personal pulse oximeter and stated, “It’s 90 %.” Resident #65 was receiving oxygen via nasal cannula at 5 Liters per minute.

An interview was conducted with the ADON on 3/29/20 at 2:25 PM. When queried regarding the IV pole, pump, and medication in the hall for a discharged Resident, the ADON looked at the medication and revealed the Resident had been “transferred to the hospital.” When queried why the pump and medication had been in the hall of the facility since 6:20 AM, the ADON was unable to provide an explanation and stated, “I will have someone take care of it.” When queried regarding the yellow colored pulse oximeter, which remained sitting on the top of the medication cart, without a plastic battery cover including infection control and cleaning, the ADON indicated they were unaware and removed the pulse oximeter.
On 3/29/20 at 2:30 PM, Resident #703 was observed in bed, positioned on their back in the isolation unit of the facility. An interview was conducted with the Resident at this time. When asked when they were transferred to the isolation unit, Resident #703 stated, "I think Tuesday. I started feeling bad on Saturday." With further inquiry, Resident #703 then stated, "My roommate (Resident #704) was real sick. They got moved on Saturday (to isolation unit)." When asked their symptoms, Resident #703 stated, "I got confused, I'm confused. I'm short of breath. I just don't feel good." Resident #703 then began coughing. The Resident was receiving oxygen via nasal cannula but became visibly short of breath and fatigued when speaking.

An interview was conducted with LPN "B" on 3/29/20 at 2:35 PM. When queried regarding Resident #703's roommate, LPN "B" revealed their roommate was (Resident #704). When asked where Resident #704 was at this time, LPN "B" revealed they were in the hospital but was unsure of the Residents condition.

On 3/29/20 at 2:40 PM, a tour of the isolation unit of the facility revealed all Resident room doors remained open, including the Resident with confirmed Covid-19.
Record review of Resident #703’s medical record revealed the Resident was originally admitted to the facility on 7/21/17 with diagnoses which included Congestive Heart Failure (CHF), Chronic Obstructive Lung Disease (COPD), and diabetes mellitus. Review of the Minimum Data Set (MDS) assessment dated 1/29/20 revealed the Resident was cognitively intact and required supervision to limited assistance to perform Activities of Daily Living (ADLs).

Review of Resident #703’s vital sign documentation revealed the Resident had abnormal temperatures documented on:

-3/26/20 at 9:26 AM: 102.5 degrees Fahrenheit (Tympanic)- Documented by LPN "'F’"

-3/26/20 at 9:22 AM: 100.2 degrees Fahrenheit (Tympanic)- Documented by LPN "'CC’"

Review of Resident #703’s progress note documentation in the medical record revealed the following:
<table>
<thead>
<tr>
<th>Date</th>
<th>Note Description</th>
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| 3/16/20  | Nurse Practitioner Note... Reason for visit: Was called to evaluate resident for c/o (complaints of) severe chest pain..."
| 3/24/20  | Physician Progress Notes... Congestion... occasional cough... will order chest X-ray..."
| 3/25/20  | Nurse Practitioner Note... Reason for visit: was called to evaluate resident for acute change in condition- malaise, cough... Nurse reports pt (patient) lethargic earlier this morning. + NP cough. SPO2 currently 90%, decreased from 95%. Pt (patient) placed on O2 (oxygen) NC (Nasal Cannula) ... CXR and labs were ordered yesterday. Results not available... In bed, appears weak and mildly ill... Lung sounds diminished overall... Assessment Plan: cough... will reorder CXR and labs. Continue O2 NC. Monitor T, HR, SPO2 2x a shift..."
| 3/26/20  | Physician Progress Notes... Chief Complaint: fevers, malaise, cough resident high risk for COVID 19, resident with multiple co-morbid conditions... Temperature: 101.2 degrees Fahrenheit... upper airway congestion Wheezes... transfer to contact isolation precautions, high suspect COVID 19 we will continue with oxygen for...
Review of facility provided information indicated the Resident first displayed signs and symptoms of Covid-19 on 3/17/20 and was transferred to the isolation unit on 3/26/20.

Review of Resident #704’s medical record revealed the Resident was originally admitted to the facility on 4/16/13 with diagnoses which included dementia, above the knee amputation, phantom lower extremity pain, dysphagia (difficulty swallowing), and Chronic Obstructive Lung Disease (COPD). Review of the Minimum Data Set (MDS) assessment dated 2/16/20 revealed the Resident was cognitively intact and required supervision to limited assistance to perform Activities of Daily Living (ADLs).

Record review further revealed Resident #704 was transferred to the hospital on 3/22/20 and had not returned to the facility.

Review of Resident #704’s medical record revealed the following progress note documentation:
**Health Status Note...**

Residents had emesis times one... did complain of coughing with the one emesis...

**Nurse Practitioner Note...**

Reason for visit: Was asked to evaluate resident for c/o N/V (Nausea/Vomiting) ... reports they have been vomiting for last 2 days. (Resident #704) has had no appetite and poor oral intake...

**Health Status Note...**

Resident c/o nausea...

**Nurse Practitioner Note...**

Reason for visit: Was asked to evaluate resident for persistent c/o N/V ... seen today per nurse request for above complaints. (Resident #704) reports they have been vomiting for last 4 days... has had no appetite and poor oral intake...

**Health Status Note...**

Resident not feeling so good today. c/o nausea...
-3/20/20: "Nurse Practitioner Note... Reason for visit: Was asked to evaluate resident for persistent c/o N/V; AMS (Acute Mental Status change) ...Pt seen today per nurse request for above complaints. (Resident #704) has been vomiting for last 5-6 days... no appetite and poor oral intake... Will order labs to be drawn and start gentle hydration with normal saline... Monitor T, HR, SPO2 closely. Pt is at risk for... Covid19. Will need close monitoring..."

3/22/20: "Nurses Note...Resident pulse ox @ 85% on non rebreather mask. Unable to increase oxygenation... Order to transfer resident to (hospital)"

Review of Vital Sign Documentation for Resident #704 revealed the following:

-3/22/20 at 8:03 AM: SPO2 89 % on Oxygen via Nasal Cannula

-3/22/20 at 11:35 AM: SPO2 83 % on High
Flow Oxygen

Resident #704’s medical record also included an order, dated 3/21/20 at 10:41 AM specifying, “Oxygen 2L (Liters) NC (Nasal Cannula) continuous for hypoxemia.”

An interview was conducted with LPN “C” on 3/31/20 at 9:48 AM. When queried if they had provided care to Resident #703, LPN “C” revealed they had. When asked if the Resident had any signs or symptoms of Covid-19, LPN “C” stated, “(Resident #703) was. They complained of a cough.” LPN “C” was then asked when the Resident was transferred into the isolation unit. LPN “C” reviewed the Resident’s medical record and stated, “(On the 26th (3/26/20).” When queried if they had cared for Resident #704, LPN “C” revealed they had and were also the Resident’s nurse when they were transferred to the hospital. When asked what had occurred, LPN “C” stated, “(Resident #704) wasn’t as alert as they normally were. Their oxygen stats were up and down between 80 and 85 percent.” When asked what actions were taken at the facility, LPN “C” stated, “I put (Resident #704) on a non-rebreather (oxygen delivery device mask used to deliver high flow oxygen) at 15 liters. (Resident #704) would only go up 85- 87% on the non-rebreather.” “When asked, LPN “C” further revealed Resident #704 was “only down
there a few days. (The Resident) had a positive chest X-ray and a cough before they were moved to the isolation unit."" When queried regarding the facility policy/procedures related to being moved/ transferred into the isolation unit, LPN ""C"" replied, ""The requirements to move down are cough, hypoxic, X-ray changes, fever."" When queried if Resident #704 had a temperature documented in the medical record, LPN ""C"" reviewed the record and stated, ""No, I don’t see one (elevated temperature) either but I know they (facility management/ administration) said it was a requirement to move down here (isolation)."" With further inquiry, LPN ""C"" indicated the Resident may have had a temperature but it ""might not have gotten"" documented in the Resident’s chart. LPN ""C"" was then asked if Residents who are transferred to the hospital are supposed to have a Transfer or Change of Condition Assessment documented in the medical record per facility policy/procedure and stated, ""We haven’t been doing them (assessments) because they (have) been emergency transfers."" When asked if they were aware of Resident #701 having a decline or hypoxemia prior to having to be transferred on 3/22/20, LPN ""C"" stated, ""In report (Nurse ""EE") said to watch (Resident #704) because they were worried about them. (Nurse ""EE") said (Resident #704) don’t look to good."" With further inquiry, LPN ""C"" specified that in report, Nurse ""EE"" revealed Resident #704 was ""on 5 liters of oxygen and they couldn’t get them above the high 80’s SPO2."" LPN ""C"" was then queried if they had cared for Resident #701 and replied they had. When queried regarding Resident #701 having signs/symptoms of Covid-19, LPN ""C"" revealed the Resident had a cough. When
asked the date Resident #701 was transferred to the isolation unit, LPN ""C"" stated, ""3/28."" When queried regarding documentation in the medical record on 3/26/20 indicating Resident #701's SPO2 had decreased from baseline and why the Resident was not moved to the isolation unit until the 28th, LPN ""C"" was unable to provide an explanation.

A phone interview was attempted to be completed with Nurse ""EE"" on 3/31/20 at 10:40 AM. A voicemail message with return phone number was left.

On 3/31/20 at 10:55 AM, an interview was completed with Resident #704’s Family Member ""D"". When queried regarding Resident #704's care in the facility, Family Member ""D"" revealed they were informed (Resident #704) had pneumonia by the facility and were sent to the hospital on 3/22/20. Family Member ""D"" then stated, ""(Resident #704) is on a ventilator now and is in isolation. They (hospital) tested (Resident #704) for Coronavirus and are treating them like they have it."" With further inquiry regarding the Resident's care in the facility, Family Member ""D"" stated, ""It's not the greatest. They use a lot of temporary people. The housekeeping was terrible.""
A phone interview was attempted to be completed with LPN "'E'" on 3/31/20 at 11:12 AM. A voicemail message was left with return phone number. An interview was conducted with LPN "'F'" on 3/31/20 at 11:15 AM. When asked if they had provided care to Resident #''s 701, 702, 703, and 704, LPN "'F'" stated, "'All I did was document the Covid Assessment.'" With inquiry regarding their actions when completing the Covid Assessment, LPN "'F'" replied, "'I come in and document the temp (temperature). I go to every Resident, take their temp, and put it on their sheet (electronic Covid-19 assessment).'" When asked if they do anything other than take Resident temperatures, LPN "'F'" stated, "'No. If I have any temps, I let the nurse know.'" When queried if they auscultate Resident lung sounds when they document the "'Lung Assessment'" section on the Covid-19 assessment in Residents medical records, LPN "'F'" stated, "'I don't take lung sounds. I know what a wheeze sounds like. If I don't hear anything, I say their lungs are clear.'" When asked if they are supposed to auscultate lung sounds per facility policy/procedure and how they are able to determine changes in Resident condition without auscultating lung sounds, LPN "'F'" replied, "'It might be a good idea to do that. No one has said anything to me about it.'"

An interview was conducted with the Director of Nursing (DON) on 3/31/20 at 11:50 AM.
When queried regarding facility policy/procedure and expectations when completing the Lung assessment section of the Covid-19 assessment, the DON stated, ""I expect them (staff) to let me or Infection Control know if there is something changed."" The DON added, ""We actually have a nurse (LPN ""F") who is coming in just to do the assessments Monday to Saturday."" When queried if the expectation is that nursing staff auscultate lung sounds when completing the Lung assessment section, the DON stated, ""Yes, they are listening to lung sounds."" The interview with LPN ""F"" was discussed with the DON at this time. When queried regarding LPN ""F"" stating they are not auscultating lung sounds when completing the Lung assessment section, the DON stated, ""Yes, they are listening to lung sounds."" The interview with LPN ""F"" was discussed with the DON at this time. When queried if the expectation is that nursing staff auscultate lung sounds when completing the Lung assessment section, the DON stated, ""Yes, they are listening to lung sounds."" The interview with LPN ""F"" was discussed with the DON at this time. When queried regarding LPN ""F"" stating they are not auscultating lung sounds the DON replied, ""I was not aware of that. They are supposed to be listening."" The DON was then asked if Nurse ""EE"" and LPN ""E"" were currently working due to being unable to reach them by phone and replied, ""(Nurse ""EE") is off sick and (LPN ""E") is in the hospital."" With further inquiry regarding employee illnesses in the facility, the DON revealed the reason for LPN ""E"" being hospitalized and Nurse ""EE"" being off was related to Covid-19 infection/signs and symptoms.

On 3/31/20 at 1:30 PM, a phone call was received from Family Member ""D"". Family Member ""D"" revealed they were calling to provide an update that Resident #704 was not doing well and was being ""taken off the vent today.""
Facility requested infection control tracking and surveillance documentation was requested on 3/29/20 at 12:09 PM and on 3/31/20 at 8:43 AM and 2:18 PM. The information was received on 3/31/20 at 3:03 PM.

On 3/31/20 at 4:21 PM, an interview was conducted with the Director of Nursing (DON). When queried regarding the facility policy/procedure pertaining to Covid-19 assessments, the DON reported, """"There are no policy/procedure for the Covid Assessment but we are completing it for all residents daily."

A review of the Facility COVID 19 line listing as of 03/30/20 revealed: Resident #707 had onset of symptoms recorded as 3/12/20. Resident #707 resided on two (second floor) north. A second resident (non-sampled resident) NSR #1 on two north had onset of symptoms recorded as 3/12/20. Both residents tested positive for the COVID 19 virus; both residents died. A third two north resident NSR #2 developed symptoms on 3/23/20 and died. A roommate of NSR #2 developed symptoms on 3/27/20. An additional five two north residents developed COVID 19 symptoms and one of those NSR #3 developed symptoms on 3/24/20 was hospitalized and died. This included Resident #708 (the roommate of NSR #3) who also developed symptoms on 3/24/20. An additional nine residents of the second floor.
developed COVID 19 symptoms including Resident #67; Two of these died-Resident #706 and NSR #4. On the first floor 26 residents developed symptoms; 25 of these were on the north unit; Seven were hospitalized; Two died-Resident #705 and Resident #709. 17 staff members were recorded with COVID like symptoms with three positive for COVID 19 and symptom onset as early as 3/16/19; one from the kitchen staff, one who worked "all" floors and one maintenance staff.

A review of the facility record for Resident #705 revealed an admission into the facility on 08/28/19. Diagnoses include Heart Disease, Diabetes and Sleep Apnea. COVID assessments from 03/17/20 through 03/21/20 revealed no fever cough or congestion. A nurse note dated 3/22/20 at 2:32 PM revealed, "Spoke to (wife) and informed her that resident was pronounced at 1327 (1:27 PM). A nurse note dated 3/23/20 revealed, "Writer was summoned to room at approximately 130 PM and observed resident laying in bed, attempted to obtain heart rate but was unsuccessful. Writer summoned for help by calling a code blue over the intercom system. CPR (cardio pulmonary resuscitation) initiated and 911 called. Chest compressions started at 1403 (2:03 PM), CPR non effective. 911 on scene at approximately and pronounced time of death at 1427 (2:27 PM).

A review of the facility record for Resident
#706 revealed and admission into the facility on 11/12/18. Diagnoses include Weakness, Dysphagia (trouble swallowing) and Difficulty walking. A nursing progress note by Nurse "FF" dated 3/21/20 revealed, "Patient was complaining of not feeling well, vitals taken patient temp was 101.9, patient was lethargic and weak, moved patient to south unit doctor notified." An NP note dated 03/23/20 revealed, "Was asked to evaluate resident for hypoxemia (low blood oxygen), fever, nausea/vomiting, recently placed in droplet isolation for report of high fever." An NP progress note dated 03/24/20 at 2:50 PM, revealed, "Reason for visit: hypoxemia, tachycardia, tachypnea (rapid breathing), nausea/vomiting...recently placed in droplet isolation for suspected COVID 19 infection...breaths shallow. Diminished Breath sounds." A nurse progress note dated 3/24/20 at 4:54 PM, revealed, "Resident diaphoretic (sweating) and clammy, rapid breathing respirations at 38 93% on 15 Liters of 02. Disoriented, unable to focus or respond to yes no questions. Resident transferred to hospital via 911." COVID assessments were reviewed for 3/17/20 through 3/21/20. No cough or congestion or fever was reported on each.

A review of the facility record for Resident #707 revealed and admission into the facility on 11/6/19. Diagnoses include Diabetes, Depression and Stroke. A "Change in Condition Evaluation" form dated 3/12/20 reported an acute mental status change and fever and Resident #707 was sent to the hospital. An NP progress noted dated 3/12/20 revealed: "Resident with increase in..."
confusion, slow to respond and unable to articulate speech during this visit. discuss with staff, we will send to hospital for evaluation."

A review of the facility record for R708 revealed and admission into the facility on 11/06/19. Diagnoses include Dementia, Depression and Muscle Wasting. The care plan revealed, ""I am dependent on staff for meeting emotional, intellectual, physical, and social needs related to: Cognitive deficits, Immobility, Physical Limitations."" A social work note dated 3/19/20 revealed, ""Writer met with resident in his room, mood was calm. Resident is alert and oriented to self. Guardian notified of scheduled care...COVID -19 precautions are in place..."" A nurse note dated 3/24/20 at 5:34 PM revealed, ""patient was experiencing respiratory distress, O2 level 79% on room air. Nurse placed oxygen on patient at 5 Liters. Patient oxygen still didn’t increase. Patient having labored breathing and experiencing elevated respiration rates. Had to increase patient on oxygen to 12 Liters to maintain at a safe level. Order to send patient out to hospital by NP. Patient transferred to (hospital) at 10:00 am. Notified doctor and daughter."" The facility COVID line list recorded symptom onset as 3/24/20. COVID assessments were reviewed for 3/17/20 through 3/21/20. No cough or congestion or fever was reported on each. COVID assessments were reviewed for 3/17/20 through 3/21/20. No cough or congestion or fever was reported on each. A temperature on 03/20/20 was 99.0 F.
A review of the facility record for Resident #709 revealed and admission into the facility on 2/06/20. Diagnoses include Chronic Obstructive Pulmonary Disease and Oxygen Dependance. A nurse note dated 3/23/20 at 10:44 AM revealed, ""At approximately 0500 (5AM), writer in to render care and observed resident in distress. Writer attempted to assess heart rate and spo2 but attempts were unsuccessful, CPR initiated and 911 notified per staff nurse. Paramedics on scene at approximately 0505. CPR continued per nursing staff. Paramedics assessed resident, unable to obtain blood pressure, heart rate or spo2."" COVID assessments were reviewed for 3/17/20 through 3/21/20. No cough or congestion or fever was reported on each.

On 3/31/20 at 5:15 PM, an interview was conducted with the ADON/Infection Control Nurse. When queried regarding no line listings for infections provided from February 2020, the ADON indicated they were unsure why they were not provided. The ADON was asked when Covid-19 infections first began in the facility and stated, ""March 12th (2020)."" When asked if there were any infections prior, the ADON revealed a discharged resident had been sick on 3/2/20. When asked when infection tracking and mapping is completed, the ADON stated, ""I don’t get my line listing off the carts until the first of the month so I will get it tomorrow."" When asked how they completed real time tracking and monitoring to prevent further spread of Covid-19 when
identified within the facility if they do not collect line listing information until the end of the month, the ADON replied, "Not in my notes but in my personal tracking." With further inquiry, the ADON revealed they also look at the Dashboard in the computer and it tells them if there was an antibiotic order or change in condition assessment completed. When asked how they are notified if an assessment is not completed, the ADON did not provide an explanation. When queried if they had identified any patterns and/or similarities in the infections, the ADON revealed they had not identified any patterns. When queried regarding staff illness and call-in tracking including the staff member hospitalized for Covid-19, the ADON indicated there were multiple facility staff off sick. When queried regarding tracking of Therapy staff illness and call-in tracking including the staff member hospitalized for Covid-19, the ADON indicated there were multiple facility staff off sick. When queried regarding tracking of Therapy staff illness and other contracted employees/services at the facility, the ADON replied, "I don’t track therapy. They aren’t the same company." With further inquiry regarding Therapy staff having direct contact with facility Residents and infection control, the ADON stated, "They will inform me, but I don’t track them. I don’t get their call-in forms at all and now their therapy director is off as well. It is not required of me to track it." No further explanation was provided. Review of provided mapping and line listing documentation revealed multiple inconsistencies between the listing and the map. When queried, the ADON revealed they "missed those ones." When asked if the staff call-in list provided were all the staff call-ins for the facility, the ADON reviewed the list and stated, "No, I got a few call-ins that aren’t on there." The ADON then stated, "I’m gonna be honest. It’s been really hard to track. Some people are no-call/no-show." No further explanation was
On 4/2/20 at 9:30 AM, a phone call was received from Family Member "D". Family Member "D" revealed Resident #704 had passed away after being removed from the ventilator on 3/31/20. Family Member "D" further detailed the hospital told them they believed the cause to be Covid-19 but the test results would be reported to them by the CDC.

A review of the record for R711 revealed:

- R711 was admitted into the facility on 09/30/19. Diagnoses included, Dementia, Anxiety and Cancer. COVID 19 assessments for R711 from 03/17/20 to 03/31/20 documented no fever, cough or congestion. A review of the Nurse Practitioner NP note dated 03/31/20 revealed: "Reason for Visit: PNA (pneumonia); high rate of COVID 19 exposure in facility. Pt (Patient) was noted to have increased cough with copious secretions (congestion) and hypoxemia (low oxygen/shortness of breath) over the weekend, left eye opaque, yellow crusts to lid margins, will start Azithromycin (antibiotic) and transfer to isolation unit. High rate of exposure of COVID 19 in facility." A nurse progress note dated "3/29/2020, 2:22 PM, resident observed choking on secretions. Vitals are as follows: BP 157/118 T 97.9 R 21 P 50 Spo2 87% assessment findings: audible crackles in both lungs." These notes contradict the COVID assessment findings.
A review of the Facility COVID 19 line listing as of 03/30/20 revealed: R707 had onset of symptoms recorded as 03/12/20. R707 resided on two (second floor) north. A second resident Non Sampled Resident (NSR)1 on two north had onset of symptoms recorded as 03/12/20. Both residents tested positive for the COVID 19 virus; both residents died. A third two north resident NSR2 developed symptoms on 03/23/20 and died. A roommate of NSR2 developed symptoms on 03/27/20. An additional five two north residents developed COVID 19 symptoms and one of those NSR3 developed symptoms on 03/24/20 was hospitalized and died. This included R708 (the roommate of NSR3) who also developed symptoms on 03/24/20. An additional nine residents of the second floor developed COVID 19 symptoms including R67; Two of these died-R706 and NSR4. On the first floor 26 residents developed symptoms; 25 of these were on the north unit; Seven were hospitalized; Two died-R705 and R709. 17 staff members were recorded with COVID like symptoms with three positive for COVID 19 with symptom onset as early as 03/16/19: one from the kitchen staff, one who worked ""all"" floors and one maintenance staff (per facility staff).

A review of the facility record for R705 revealed an admission into the facility on 08/28/19. Diagnoses include Heart Disease, Diabetes and Sleep Apnea. COVID assessments from 03/17/20 through 03/21/20 revealed not fever cough or
congestion. A nurse note dated 03/22/20 at 2:32 PM revealed, "Spoke to (wife) and informed her that resident was pronounced at 1327 (1:27 PM). A nurse note dated 03/23/20 revealed, "Writer was summoned to room at approximately 130 PM and observed resident laying in bed, attempted to obtain heart rate but was unsuccessful. Writer summoned for help by calling a code blue over the intercom system. CPR initiated and 911 called. Chest compressions started at 1403 (2:03 PM), CPR non effective. 911 on scene at approximately and pronounced time of death at 1427 (2:27 PM).

A review of the facility record for R706 revealed and admission into the facility on 11/12/18. Diagnoses include Weakness, Dysphagia (trouble swallowing) and Difficulty walking. A nursing progress note by Nurse "FF" dated 03/21/20 revealed, "Patient was complaining of not feeling well, vitals taken patient temp was 101.9, patient was lethargic and weak, moved patient to south unit doctor notified." An NP note dated 03/23/20 revealed, "Was asked to evaluate resident for hypoxemia (low blood oxygen), fever, nausea/vomiting, recently placed in droplet isolation for report of high fever." An NP progress note dated 03/24/20 at 2:50 PM, revealed, "Reason for visit: hypoxemia, tachycardia, tachypnea (rapid breathing), nausea/vomiting...recently placed in droplet isolation for suspected COVID 19 infection...breaths shallow. Diminished Breath sounds." A nurse progress note dated 03/24/20 at 4:54 PM, revealed, "Resident diaphoretic (sweating) and clammy, rapid breathing respirations at 38
93% on 15 Liters of O2. Disoriented, unable to focus or respond to yes no questions. Resident transferred to hospital via 911. COVID assessments were reviewed for 03/17/20 through 03/21/20. No cough or congestion or fever was reported on each.

A review of the facility record for R707 revealed and admission into the facility on 11/06/19. Diagnoses include Diabetes, Depression and Stroke. A "Change in Condition Evaluation" form dated 03/12/20 reported an acute mental status change and fever and R707 was sent to the hospital. An NP progress noted dated 03/12/20 revealed: "resident with increase in confusion, slow to respond and unable to articulate speech during this visit. discuss with staff, we will send to hospital for evaluation."

A review of the facility record for R708 revealed and admission into the facility on 11/06/19. Diagnoses include Dementia, Depression and Muscle Wasting. The care plan revealed, "I am dependent on staff for meeting emotional, intellectual, physical, and social needs related to: Cognitive deficits, Immobility, Physical Limitations." A social work note dated 03/19/29 revealed, "Writer met with resident in his room, mood was calm. Resident is alert and oriented to self. Guardian notified of scheduled care...COVID -19 precautions are in place..." A nurse note dated 03/24/20 at 5:34 PM revealed, "patient was experiencing respiratory distress, O2 level 79% on room air. Nurse
placed oxygen on patient at 5 Liters. Patient oxygen still didn’t increase. Patient having labored breathing and experiencing elevated respiration rates. Had to increase patient on oxygen to 12 Liters to maintain at a safe level. Order to send patient out to hospital by NP. Patient transferred to (hospital) at 10:00 am. Notified doctor and daughter."

The facility COVID line list recorded symptom onset as 03/24/20. COVID assessments were reviewed for 03/17/20 through 03/21/20. No cough or congestion or fever was reported on each. COVID assessments were reviewed for 03/17/20 through 03/21/20. No cough or congestion or fever was reported on each. A temperature on 03/20/20 was 99.0 F.

A review of the facility record for R709 revealed and admission into the facility on 02/06/20. Diagnoses include Chronic Obstructive Pulmonary Disease and Oxygen Dependance. A nurse not dated 03/23/20 at 10:44 AM revealed, ""At approximately 0500 (5AM), writer in to render care and observed resident in distress. Writer attempted to asses heart rate and spo2 but attempts were unsuccessful, CPR initiated and 911 notified per staff nurse. Paramedics on scene at approximately 0505, CPR continued per nursing staff. Paramedics assessed resident, unable to obtain blood pressure, heart rate or spo2."

COVID assessments were reviewed for 03/17/20 through 03/21/20. No cough or congestion or fever was reported on each.
A review of the facility policy titled, “Management of Outbreak of Communicable Diseases (undated)” revealed: “Policy Statement: Outbreaks of communicable diseases within the facility will be promptly identified and appropriately handled.

Fundamental Information

An outbreak is typically one or more of the following: One case of an infection that is highly communicable. Trends that are 10 percent higher than the historical rate of infection for the facility that may reflect an outbreak or seasonal variation and therefore warrant further investigation; or Occurrence of three or more cases of the same infection over a specified length of time on the same unit or other defined areas. An outbreak of influenza is defined as three percent or more of the resident population within a seventy-two (72) hour period. Procedure: 1. When a potential outbreak of a communicable disease arises, the Infection Prevention and Control Nurse should take aggressive steps to contain the disease and prevent spreading. 2. Contacts are to be cultured as directed by the health department, medical director, and /or attending physician(s). 3. Symptomatic residents and employees are to be considered potentially infected and are to be cultured and isolated as indicated. 4. Administration will be responsible for: a. Telephoning report to health department; b. Closing admissions to the facility until four (4) days after the last reported case or as
authorized by health department; c. Submitting daily progress reports to the health department; d. Calling emergency meetings of the Infection Prevention and Control Committee; e. Discontinuing group activities, as indicated; f. Limiting visitors if indicated (i.e., influenza in the community); and g. Forwarding Communicable Disease Report Cards to the health department. 5. The director of nursing services will be responsible for: a. Receiving surveillance information and tabulating data; b. Maintaining line listing of identified cases. c. Notifying the medical director and the attending physician; d. Assigning nursing personnel to same residents group for the duration of the outbreak. 6. The nursing staff will be responsible for: a. Notifying the director of nursing services of symptomatic residents; b. Providing infection surveillance data in a timely manner; c. Obtaining laboratory specimens as directed. d. Initiating isolation barriers as directed or as necessary; and e. Confining symptomatic residents to their rooms for at least seventy-two (72) hours after onset of symptoms. 7. It is the responsibility of all employees to:

a. Practice good hygiene and good hand washing; b. Report illness to their supervisor; and

c. Follow infection control guidelines as outlined in the facility protocols. 8. The medical director is responsible for: a. Working with the attending physicians and
9. The attending physician or designee will be responsible for:
a. Visiting the resident within twenty-four (24) hours after being notified of the condition.
b. Ordering isolation barriers, as needed;
c. Working with the medical director and health department to determine the need for laboratory specimens;
d. Determining the need for follow-up specimens and discontinuing isolation barriers.
e. Obtaining throat specimens for viral culture in an influenza outbreak, and
f. In the event of an influenza A outbreak, determining the need for antiviral therapy."

A review of the CDC.gov ""Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies. Limited re-use of N95 respirators for COVID-19 patients"" revealed, ""Limited re-use of N95 respirators when caring for patients with COVID-19 might become necessary. However, it is unknown what the potential contribution of contact transmission is for SARS-CoV-2 (COVID), and caution should be used. Re-use should be implemented according to CDC guidance. Hang used respirators in a designated storage area or keep them in a clean, breathable container such as a paper bag between uses. Respiratory pathogens on the respirator surface can potentially be transferred by touch to the wearer’s hands and thus risk causing infection through subsequent touching of the mucous
membranes of the face (i.e., self-inoculation)."

A review of the manufacturer’s inserts for the two respirators reported in use at the facility revealed, ""Use information: 2. Before occupational use the wearer must be trained by the employer in the correct use of the respirator in accordance with applicable safety and health standards; 3. OSHA standards require that the wearer be fit tested. 5. Discard the respirator and replace with a new one after every use. Precautions: Do not reuse N95 respirator or hang around neck between patients. Conduct a user seal check before each use...If you can not achieve a proper seal do not use the respirator.""

A review of the facility policy titled, ""Cleaning Isolation Room (undated)"" revealed: ""Policy

The facility will maintain the cleanliness of Isolation Rooms on a daily basis. Procedure:

Equipment and Supplies: 1. Do not store cleaning supplies or equipment in resident’s rooms.
2. Use fresh solution, clean equipment, and clean mops for each room. 3. Discard cleaning cloths and mop heads used in isolation rooms, or follow laundry procedures. Daily Cleaning

1. Have nursing personnel clean all utensils and change linen using proper bagging techniques. 2. When possible, clean isolation rooms at the end of the daily schedule.

A review of the facility policy titled, "Transmission Precautions-Droplet (undated)" revealed, "Purpose: In addition to Standard Precautions, Droplet Precautions are used with residents known to be infected, or suspected of being infected, with microorganisms transmitted by droplets that can be generated during coughing, sneezing, talking, or while performing procedures (for example suctioning and bronchoscope). Procedure: 1. Resident Placement: Place the resident in a private room if available. Place the resident in a room with a resident infected with the same organism (cohorting) if a private room is not available. If a private room or cohorting are not available, options are: The resident may share a room with an uninfected low risk resident. A separation of three feet must be maintained between the infected resident and other residents and visitors. 2. Hand washing: Wash hands
thoroughly between residents, after removing gloves, and before leaving the resident room. Wash hands thoroughly after contact with any body substance, equipment, or articles contaminated with any body fluid. 3. Wear gloves when contact with any body substance is anticipated. 4. Gowns must be worn when working within three feet of the resident. 5. A mask must be worn when working within three feet of the resident. 6. Resident Transport: Limit the transport of the resident from room to room to essential purposes only. If transport is necessary, minimize resident dispersal of droplets by masking the resident if possible. Or tell the resident to cover his or her mouth and nose when coughing or sneezing. 7. No special techniques are needed for resident care equipment."

A review of the facility policy titled, "Hand Hygiene (undated)" revealed: "Policy Statement:

Hand hygiene shall be regarded by this organization as the single most important means of preventing the spread of infections.

Procedure: 1. All personnel shall follow our established hand hygiene procedures to prevent the spread of infection and disease
to other personnel, patients, and visitors. 2. Hand washing with soap and water requires: a. Wetting hands first with clean, running warm water. b. Apply the amount of product recommended by the manufacturer to hands. c. Rub hands together vigorously for at least 20 seconds covering all surfaces of the hands and fingers. d. Rinse hands with water and dry thoroughly with a disposable towel. e. Turn off the faucet on the hand sink with the disposable paper towel.

3. Except for situations where hand washing is specifically required, antimicrobial agents such as alcohol based hand rubs (ABHR) are also appropriate for cleaning hands and can be used for direct resident care. 4. Appropriate hand hygiene must be performed under the following conditions: a. When coming on duty; b. Whenever hands are visibly soiled (hand washing with soap and water); Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice); c. Before and after performing invasive procedures (i.e. finger stick blood sampling); d. Before and after entering isolation precaution settings; e. Before and after eating or handling food (hand washing with soap and water); f. Before and after assisting
g. Before and after assisting a resident with personal care (i.e. oral care, bathing); k. Upon and after coming in contact with a resident’s intact skin (i.e. when taking a pulse or blood pressure, and lifting a resident); m. Before and after assisting a resident with toileting (hand washing with soap and water); n. After contact with a resident with infectious diarrhea including, but not limited to infections caused by Norovirus, salmonella, shigella, and C. difficile (hand washing with soap and water); o. After blowing or wiping nose; p. After contact with a resident’s mucous membranes and body fluids or excretions; After handling soiled or used linens, dressings, bedpans, catheters and urinals; r. After handling soiled equipment or utensils; s. After performing your personal hygiene (hand washing with soap and water) t. After removing gloves or aprons; and u. Upon completion of duty. 6. The use of gloves does not replace hand washing.”

A review of the facility policy titled, "Individual Infection Investigation (undated)" revealed: "Form’s Purpose: To provide an investigation into individual infections with the goal of identifying how the infection occurred, treatment provided, and preventative measures taken to avoid re-infection. When To Use The Form: Start a new individual infection investigation when a
A resident develops symptoms of a new infection. Each occurrence of an infection should have an individual investigation completed."

A review of the facility policy titled, "Initiating Isolation (undated)" revealed: "Purpose of Isolation precautions will be initiated when there is reason to believe that a resident has an infectious or communicable disease.

Procedure:
1. The charge nurse notifies the resident’s attending physician for appropriate isolation instructions when there is reason to believe that a resident has an infectious or communicable disease.
2. The charge nurse obtains a physician’s order for isolation.
3. Isolation precautions are initiated.
   a. Maintain an adequate supply of isolation supplies (gloves, gowns, masks, etc. as needed) near the isolation room so that appropriate protective clothing can be easily put on before entering the isolation room;
   b. Post an isolation notice on the room entrance door instructing staff and visitors to
report to the nursing station before entering the room. c. Place a container for laundry and containers for waste in or near the isolation room. d. Place necessary equipment and supplies in the room that will be needed during isolation. e. Maintain an adequate supply of antiseptic soap and paper towels in the room during the isolation period. 4. Explain to the resident, family and staff the reason(s) for the isolation precautions. 5. Maintain isolation precautions until discontinued by the attending physician.

Documentation: 1. Record in the progress notes and care plan the need for isolation, types of isolation, duration of isolation, and resident and family education.

2. Instruct employees and visitors to report to the nursing station for instructions about precautions by posting an isolation notice on the resident’s room door."

A review of the facility policy titled, ""Infection Prevention and Control Program Overview (undated)"" revealed: ""The infection prevention and control program is designed to identify and reduce the risk of acquiring and transmitting infections among residents, staff, volunteers, students, and visitors. The program incorporates a broad range of education, surveillance, prevention, and infection control practices involving all departments and is managed by the designated infection preventionist under the guidance of the Infection Preventionist."
**Fundamental Information**

The Infection Preventionist serves as the authority for overseeing the investigation, prevention, and control of infections within the facility. Review food handling practices, laundry and linen handling practices, waste disposal, pest control, traffic control, and visiting rules for high risk areas and sources for airborne infections. Infection prevention and Control Program Elements consist of:

- **Surveillance**: Based on systematic data collection to identify nosocomial infections. A system for the detection, investigation, analysis and planning to prevent and control institutional outbreak of infectious diseases. An isolation/precaution system to reduce risk of transmission of infectious agents. Interdepartmental surveillance rounds monthly. Infection control policies and procedures. In-service education in infection prevention and control. A resident health program. An employee health program and disseminate current information on all health practices to all employees. Product review/evaluation monthly, quarterly and annually. Disease reporting to public health authorities. An exposure control plan designed to eliminate or minimize employee exposure to blood borne pathogens. A tuberculosis exposure control plan for the early identification, isolation, and effective referral for treatment of persons suspected of having active tuberculosis. On a monthly basis evaluate the last quarter for possible trends compare the current month results to 1 year ago. Analysis must be done monthly, quarterly and annually.
Procedure: 1. Establish an Infection Prevention and Control Committee. 2. Designate an infection preventionist to oversee infection prevention and control practices in the facility.

3. Implement, review, approve and communicate infection prevention and control policies and procedures. 4. Implement systems for monitoring, evaluating, reporting, and controlling the spread of infections. 5. Implementing systems to prevent, identify, control, report and manage outbreaks. 6. Implement on-going intradepartmental infection control training regarding the transmission and prevention of infectious disease.

A review of the facility policy titled, "Infection Prevention and Control Education (undated)" revealed: "Employees are instructed in infection control practices during the orientation process and at periodic in-services. Fundamental Information Educating..."
the facility staff in infection control practices is a major ongoing responsibility of the designated infection control nurse. Procedure: 1. Instruct employees on how to maintain good health practices and personal hygiene to include, Hand washing, Body cleanliness, Clean clothing, Covering of the nose or mouth when sneezing or coughing, Standard Precautions. 2. Teach employees to consider blood and all body fluids, except sweat, as potentially infectious. 3. Educate employees to report significant infectious illnesses to their supervisor or the designated infection control nurse. Documentation: Record infection prevention and control education on the orientation checklist or inservice record."

A review of the facility policy titled, "Infection Control Line Listing (undated)" revealed: "Form "s Purpose: To maintain a list of facility-wide individual infections that will provide the data necessary both for early detection of infection issues and for evaluation of the infection control program. When To Use The Form Start a new form on the first of each month. Active infections from previous month should be tracked by the Infection Preventionist but, not calculated as a new infection for the current month. The form will be placed in the front of the medication record. How To Use The Form 1. When symptoms of infection or an infectious diagnosis is given by the physician, enter the information onto the infection control form. Include the resident "s name, date of admission, date symptoms first noted, symptoms, culture result, organism (when indicated), antibiotic ordered, date cleared,
and outcome. 2. Use this form to complete the Monthly Analysis of Infections. 3. Analyze the data, and complete an Action Plan for resolution of meeting. Form "s Disposition: File the form with the QAPI Committee minutes."

Abatement Plan provided by facility: March 29, 2020

**Element 1**

- Dedicated vital signs equipment will be used on isolation unit and will be cleaned following manufacturer’s recommendations between each resident used.

- Nurse #.1 and nursing staff have been re-educated on proper use of wrist BP machine

- The unlabeled sanitizer bottle was removed from Nurse #.2 and Nurse X.2 was re-educated that only labeled chemicals are allowed to be used in the facility.
Nursing staff have been re-educated on the facility policy for hand hygiene.

*Check point has been established at the entrance to the isolation unit to ensure PPE is used per facility policy upon entering the unit and removed when exit. PPE standards have been posted on the isolation unit including the use of goggles, N95 respirator masks, disposable gowns, gloves and a bin has been placed at the entrance check point for disposal upon leaving the unit. Staff have been re-educated on donning and doffing PPE per facility policy and best practices.

* Staff have been re-educated on the use of Privacy curtains between residents in semi-private rooms throughout the center.

Element 2

*All residents have the potential to be affected. Infection prevention guidelines and COVID-19 facility policies have been reviewed and deemed appropriate.
**Element 3**

Education were completed on the following:

- 100% of current license staff were re-educated on 3-29-2020, and ad hoc QAPI was held today to review the facility infection control guidelines and COVID-19 Guildlike, MI state concerns and to develop and abatement process.

- Hand Washing between meal trays, and overall

- Cleaning equipment between residents

- Keeping curtains pulled between residents

- Keeping doors closed on Isolation unit
**Using electronic BP per manufacturer’s recommendations**

**Proper PPE use when going in between Isolation vs non-isolation units**

**Re-educating staff on infection control guidelines and COVID-19 guidelines**

**only using labeled chemicals allowed to be used in the facility**

**Creation of the checkpoint for between Isolation and non-Isolation**

**Dining PPE per center P&amp;P**

**Maintenance will Install a Curtain In room 134 by EOD 3-29-2020 and set up room to keep residents’ beds in room 134 at least**
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<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td>&quot;&quot;&quot; On Isolation unit ensure doors closed to rooms, garbage cans, and hand sanitizer inside double door</td>
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