

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/29/2020
NAME OF PROVIDER OR SUPPLIER TOMAH NURSING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 BUTTS AVE TOMAH, WI 54660		
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F 000	INITIAL COMMENTS This was a complaint, focused infection control and partial extended survey conducted at Tomah Nursing and Rehab from 12/14/20 through 12/29/20. This survey identified substandard quality of care at F684. Federal citations issued: 4 The most serious citation is F684 and F580 cited at a severity/scope level of J (Immediate Jeopardy/isolated). Census: 30 Sample size: 15	F 000			
F 580 SS=J	Notify of Changes (Injury/Degrade/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 580	<p>Continued From page 1</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure the physician was immediately consulted with regarding a significant change of condition for 1 out of 15 total sampled Residents (R7)</p> <p>R7 had a change in condition. The facility failed to complete a RN (Registered Nurse) assessment and failed to notify the physician as R7's condition continued to deteriorate. R7 was hospitalized</p>	F 580	Past noncompliance: no plan of correction required.		

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F 580	<p>Continued From page 2 with dehydration and an infected parotid gland.</p> <p>The facility's failure to timely consult with the physician created a finding of Immediate Jeopardy that began on 12/14/20. The NHA A (Nursing Home Administrator) was informed of the IJ finding on 1/12/21 at 11:00 AM. On 12/16/20, the facility recognized the deficient practice by the facility nursing staff and took steps to correct the deficient practice and ensure compliance at the time of the complaint survey. Based upon this determination, the IJ was removed and corrected on 12/17/20. This is being cited as past noncompliance.</p> <p>This is evidenced by: R7 was admitted to the facility on 10/10/20 with diagnoses that include Congestive Heart Failure, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, and Chronic Kidney Disease Stage 4.</p> <p>R7's Admission MDS (Minimum Data Set) dated 10/15/20 indicates R7 has a BIMS (Brief Interview of Mental Status) of 14 out of 15 indicating R7 is cognitively intact. R7 needs one person physical assist with supervision for transfers and bed mobility. R7 is indicated as being able to eat independently after set up. Section K indicates R7 weighs 170 pounds and R7 has no difficulties with swallowing or chewing.</p> <p>R7 fell and fractured her hip on 10/27/20 and was hospitalized through 10/30/20 when R7 was re-admitted to the facility.</p> <p>R7's MDS dated 11/4/20 indicates R7 is now moderately cognitively impaired. R7 needs an extensive two person physical assist with bed</p>	F 580			

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F 580	<p>Continued From page 3</p> <p>mobility and needs extensive assist of one for transfers. R7 is indicated as needing supervision with eating after setup. Section K indicates that R7 weighs 170 pounds and has no problems with swallowing or chewing indicated.</p> <p>On 12/13/20 at 8:21 PM, R7's Nurses Note, written by an LPN (Licensed Practical Nurse), states in part: "writer notes swollen hardness to right upper jaw approximately 4.5 inch x 4.5 inch in size. MD notified N.N.O. (no new orders) at this time. However requests to be called in AM to set up Telehealth visit for 12/14/2020 for possible antibiotic dosing. Vitals remain stable afebrile (fever free). Denies pain/discomfort to site of swelling. ...Resident took all medication as ordered one at a time with moderate fluids. Appetite noted poor with 25% intake."</p> <p>(There is no evidence that an RN went down to assess R7 at this time or that an RN was notified of R7's change in condition.)</p> <p>On 12/14/20 at 11:29 AM, R7's Nurses Note, written by DON B (Director of Nursing) states: "Teledoc visit with (physician name) today for swelling in jaw."</p> <p>The above is an inaccurate statement as R7 did not receive a teledoc (telehealth) visit from any type of provider on 12/14/20 despite the physician's request to see the resident on this date.</p> <p>On 12/15/20 at 4:25 AM R7's Nurses Note, written by a Licensed Practical Nurse, states in part: "...Resident noted with muscle guarding and facial grimacing prior to scheduled Tylenol dose as scheduled with positive effectiveness noted.</p>	F 580			

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F 580	<p>Continued From page 4</p> <p>Writer notes resident requires assist with meals and oral intake at this time. Medications were given crushed for comfort in applesauce resident tolerated well. Sips of water encouraged throughout night with total oral intake of 240 cc (cubic centimeters). Repositioning recommended r/t (related to) resident increase in staff assistance. Extensive assist of one utilized for ADL's. Resident continues to be monitored closely r/t swelling to right upper jaw MD is aware writer notes no clinical change today. ... Oral care provided by writer x2 (times two). ...will continue to monitor closely."</p> <p>(R7 is now experiencing pain, when previously on 12/13/20, when a Physician was notified, R7 was not experiencing pain to the area. R7 is requiring assist with meals and oral intake at this time and there is no indication that R7's MD was notified or updated. There is no evidence of the area being measured since 12/13/20 to ensure the area is not getting larger, or whether there is any type of redness to the area.)</p> <p>On 12/15/20 at 8:20 AM, R7's Nurses Note, written by DON B, states in part: "Family notification: Call placed with update that she did have the swelling and that MD seen her yesterday and did not make any changes. Asked to return a call as this needed to be left in a message."</p> <p>R7 was not seen on 12/14/20 by an MD or any type of Medical Provider.</p> <p>On 12/15/20 at 6:06 PM, R7's Nurses Note, written by RN N (Registered Nurse), states in part: "Resident vitals within normal limits this PM shift. Lung sounds diminished. Resident has had one medium void throughout AM shift and thus</p>	F 580			

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F 580	<p>Continued From page 5</p> <p>far none on PM shift. ...Resident's intake has been poor unless strongly encouraged and assisted by staff. Residents sister in law did come see her via window visit this early afternoon and brought chocolate ice cream which resident ate 75% of. Resident drank med pass (supplement) with early morning medication pass but declined the majority of this at lunch time and only had 25%. This PM shift resident is responding when addressed but quiet and minimal response. Is alert and orientated to person and time but attempt x 2 for correct place. Will continue to monitor resident frequently and reposition frequently. ...spoke with (MD M's name) nurse this afternoon in regards to resident condition and skin check. No new orders at this time and will plan to have meeting with (MD M) and resident tomorrow morning."</p> <p>There is no indication that MD M received the message regarding R7's condition or if RN N received a call back regarding R7 after speaking with MD M's nurse.</p> <p>On 12/15/20 at 7:05 PM, R7's Nurses Note written by RN N states in part: "Resident vital signs within normal limits but breathing is shallow. She is alert and orientated to self but states (hospital name) when asked of location and unable to determine time or date. Resident has facial grimacing present with any repositioning but unable to state where pain is. Responds very minimally to assessment questions by writer and unable to speak above a whisper. Called MD (name) to update on condition and MD ordered resident to be sent to ER (emergency room) and evaluated further ..."</p> <p>(The Physician contacted at this time is not R7's</p>	F 580			

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F 580	<p>Continued From page 6</p> <p>primary care physician. There is no evidence that the facility called to notify R7's primary care provider of R7's change in condition resulting in R7 being sent to the ER)</p> <p>On 12/15/20 at 7:30 PM, R7's Emergency Department Notes, state in part: "Physical Exam: ...(Temp) (99 degrees Fahrenheit) (respirations) 36, (blood pressure) 182/97, (oxygen) 99% on room air ... weight (138 lb. (pounds) 3.7 oz. (ounces)). Physical exam: ...she is in acute distress. Appearance: she is ill-appearing. She is not toxic-appearing. Comments: Confused, delirious appearing. HENT (Head, Ears, Nose, and Throat): ...mouth: mucous membranes are dry. ...comments: dried blood on teeth and oral mucosa. Dry mucous membranes. Swollen, tender and erythematous (red) right parotid area. ...patient given IV (intravenous fluids) and 3 g (grams) of Unasyn (antibiotic) for suppurative parotitis. ...clinical impression: 1. Suppurative parotitis. (Infection of the salivary gland) 2. Altered mental status. 3. Dehydration."</p> <p>On 12/15/20 at 10:14 PM, R7's Nurses notes indicate that R7 was transferred to another Hospital.</p> <p>On 12/16/20 at 9:13 AM R7's Hospital General Medicine Progress Note, states in part: "she's been confused for the past 2.5 days, difficulty to swallow liquids and solids for 2 days. Swelling on her face was noted starting on 12/13. Severe sepsis due to suppurative parotitis, leading to encephalopathy, dysphagia, some grunting ..."</p> <p>On 12/16/20 at 1:47 PM, R7's Nurses Note states: "Resident admitted to (Hospital name) with Dx. (diagnosis) of Dehydration and infection</p>	F 580			

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F 580	<p>Continued From page 7 in right side of face."</p> <p>On 12/16/20 at 3:03 PM, R7's Physician Note, by MD M states in part: " S: Scheduled nursing home visit via video conference under COVID quarantine. On Sunday 12/13/20, I was called by (Name of facility) nursing to report pt (patient) had swelling on the right side of her face. No fever or abnormal vitals. She was still able to speak, eat and drink. I instructed them to call the clinic first thing Monday morning to arrange a video conference so I could evaluate her face and determine if she needed antibiotics for possible dental or other infection. This was not done. On Wednesday I called at the time scheduled for our video visit, at which time I was informed the patient had been sent to the hospital last night, then transferred from (name of hospital) to (name of hospital). The charge nurse at (name of hospital) would not disclose much information ... but I was able to ascertain that the patient was admitted with dehydration, delirium and parotitis that required IV Abx (Intravenous antibiotics); she is not able to take PO's (by mouth). ... I then called patients POA (power of attorney), (name) who confirmed all of the above and also mentioned that the patients warfarin was being held because she was actively bleeding with even gentle touching of the gums and oral mucosa ..."</p> <p>On 12/17/20 at 11:03 AM, Email regarding Resident Care Concern, states in part: "(Physician name) connected with me regarding a care concern for one of his patients. On Sunday nursing home staff called (physician name) to report a patient had swelling of the right face/cheek. He determined b/c (because) no fever so [sic] didn't think she needed to go to the ER. He instructed nursing home staff he couldn't</p>	F 580			

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F 580	<p>Continued From page 8</p> <p>make a diagnosis without seeing it; since he can't come in the nursing home, he instructed them to call him first thing Monday to make a video apt. (appointment) they didn't. Tuesday night she was taken to (hospital name) and transferred to (hospital name) for a nasty infection of the parotid gland in her right cheek. She's dehydrated, delirious, and may end up needing surgery. (Physician name) feels we are dependent on nursing home staff for arranging video visits. Nursing home staff called (physician name) on Sunday to ask for advice then didn't follow through on his request to get a video visit scheduled. He feels if we had started Abx (antibiotics) early it wouldn't have gotten to this point ..."</p> <p>On 12/17/20 at 4:09 PM, R7's Nurses Note, states in part: "...Call placed to (hospital name) spoke with (name) RN. She does remain stable with improvement of less swelling. She does continue to have antibiotics for infection in parotid gland. Today did have a NG (nasogastric) tube placed as she is not taking in adequate nutrition ..."</p> <p>R7's Facility Investigation provided to Surveyor on 12/28/20 states in part: "12/14/20 ...06:00 (6:00 AM) - staff statement by (Licensed Practical Nurses name). Notified DON and day shift RN (RN H) of telehealth visit requested by MD for 12/14/2020. Staff statements by (RN H) states she didn't know the visit was not set up and needed to be. ...investigation steps: ...12/17/2020 11:03 (11:03 AM) Administrator and DON received email from (name, title, physician name) regarding concern for patient (R7's name) and no telehealth visit done/set up on 12/14/2020. (Regional Nurse Consultant's name), DON B, and</p>	F 580			

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F 580	<p>Continued From page 9</p> <p>writer (NHA A) reviewed charting again. (DON B), DON interviewed. Progress note documented on 12/14/20 at 11:29. Writer asked (DON B) is [sic] she did the teledoc visit with (Physician name) and resident. (DON B) indicated she did not, but she was aware it was supposed to happen and so she documented that it was to happen today and she thought (RN H) did the telehealth visit.</p> <p>On 12/29/20 at 10:43 AM, Surveyor interviewed RN N (Registered Nurse) regarding R7. RN N indicated she sent R7 to the ER due to the right side of her cheek being swollen. RN N indicated R7 was never seen by the (Physician name) due to a lack in communication. RN N indicated it was relayed to her that R7 had been seen by a Physician. RN N indicated that R7 was at first taking sips of fluid and that R7 had ice cream brought in for her. RN N indicate after that R7 could not drink without gurgling. RN N indicated R7 was sent to the ER due to changes in swallowing, change in mental status as R7 was not able to talk above a whisper and was not able to say where she was or what was going on. RN N indicated that R7 was assisted with meals due to having a decrease in appetite and was accepting of assistance with meals.</p> <p>On 12/29/20 at 12:45 PM. Surveyor interviewed MD M (Medical Doctor) who is R7's Primary Care Provider (PCP). MD M indicated on 12/13 he was on call that day and had received a call from the Nursing Home. MD M indicated he was told R7 had swelling in her face. MD M indicated he told the nurse to call him first thing Monday (12/14/20) in order to see her. MD M indicated he was working 12/14 and did not receive a call and did not receive a video call. MD M indicated he was working Tuesday (12/15/20) and also did not</p>	F 580			

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F 580	Continued From page 10 receive a call from the NH (Nursing Home). MD M indicated on Wednesday (12/16/20) he called the NH and found out that R7 went to the Hospital. MD M indicated that R7 was in the hospital for a parotid gland infection to the right side of her face. MD M indicated that this can happen if it's blocked or due to dehydration. MD M indicated a parotid infection itself is not a problem if caught right away. MD M indicated that R7 had a significant infection and that R7 was not with it, was unable to swallow and unable to be orientated. MD M indicated that R7 passed away yesterday (12/28/20). MD M indicated it was unexpected for R7 to pass away from a parotid gland infection. MD M stated "I'm sure she was dehydrated due to probably not eating or drinking from the infection." MD M and Surveyor reviewed R7's meal and fluid intakes. MD M indicated he was not notified of R7's decrease in meals or fluid intakes. MD M indicated he expects to be notified with a decrease in meal of fluid intake over three days. MD M indicated that a provider should have been contacted after three days maximum with a change in intakes. MD M indicated that a parotid gland infection would decrease the amount of moisture, but R7 would still have the other glands (other side of mouth and under tongue) to moisten her mouth. MD M indicated R7 had dry membranes due to dehydration. MD M reviewed R7's labs from the hospital and indicated her labs are better than expected, but at R7's baseline she is completely with it but a little fuzzy at times. MD M indicated that R7's outcome could have been different, if he had been able to see her two days sooner and had been started on antibiotics sooner. MD M indicated he would expect to be notified with any changes from baseline. MD M indicated he gave an order to have them call on Monday and they did not call, which delayed R7's	F 580			

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F 580	<p>Continued From page 11</p> <p>treatment. MD M indicated he never received a call with an update on R7's status or that she went to the hospital until he called the NH on 12/16/20.</p> <p>On 12/29/20 at 6:00 PM, Surveyor interviewed DON B regarding assessments for R7. DON B indicates they have a statement from RN H in their investigation indicating an RN looked at it and indicated there wasn't a change. DON B indicated there is no further documentation in R7's record between 12/13 and 12/15 of an assessment of the area that would include a measurement or description of the area. DON B indicated she would prefer nursing staff to assess the area at least daily. DON B indicated that R7's physician needed to be updated if there was a change or a change in condition with R7. DON B indicated based on R7's documentation in her record, you would not know if R7's swollen jaw had a change.</p> <p>The facility's failure to timely consult with the physician regarding a change of condition created a finding of IJ on 12/14/20 when R7 should have received a telehealth MD visit. The facility recognized the deficient practice and took the following corrective steps to ensure that deficient practice does not occur again: (12/16-12/17/20.)</p> <p>1) The facility completed an audit to ensure no other residents are affected.</p> <p>a. Audits will be completed daily x (times) 30 days and then weekly x 3 months and then as recommended by QAPI Committee.</p> <p>b. Educated licensed nursing staff on facility change in condition policy and procedure 12/16/20 - 12/17/20.</p> <p>c. On 12/16/20- 12/17/20 education was</p>	F 580			

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F 580	Continued From page 12 provided on change in condition & family/MD notification. Education to be provided for all licensed staff on SBAR, POA notification, MD Notification, Recognizing a Change in condition, documentation of a change in condition, notification of RN on call/ duty, and timely writing of physician orders including a request of a telehealth visit is a physician order and should be written/ completed prior to the start of their next shift. d. Administrator and DON are reviewing Facility Activity Report Daily to ensure proper completion of: SBAR, POA notification, MD Notification, Recognizing/ documenting a change in condition, notification of RN on call/ duty, and timely writing of physician orders with a change in condition. e. Education included how to document family/MD notification, recognizing change in condition - including vital signs, weight loss, and new orders - including medications. Review of what a change in condition would be and documentation requirements. f. Discrepancies will be followed up on and documentation will be verified for completion. g. The Director of Nursing is reviewing the facility progress notes via facility activity report. Records will be reviewed for proper procedure. h. The Nursing Home Administrator and Clinical team will review change in conditions daily. i. Education of license staff of recognizing change in condition and documentation j. Education of staff to update DON or RN designee with all change in condition. 2) The facility will monitor its actions through: a. Audits will be conducted by the DON or designee on the facility activity report, 24 hour nurse board, and facility activity reports. Nursing progress notes for change in condition procedure. Daily on-going.	F 580			

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F 580	Continued From page 13 b. Audits will be conducted of change in conditions have been identified timely and notifications have been completed with family/MD. c. Audits will be conducted by DON or designees for change in conditions along with proper notification timely. Daily x's 30 days then weekly x's (times) 3 months and then reviewed at next QAPI meeting for recommendations. 3) Any negative findings will be corrected immediately and referred to QAPI for follow-up. 4) Administrator will monitor to ensure compliance.	F 580			
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care 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: Based on interview and record review the facility failed to ensure that each resident receives treatment and care in accordance with professional standards of practice for 1 out of 15 total sampled Residents (R1) R1 is COVID-19 Positive and staff failed to recognize a change of condition in R1, until the NP (Nurse Practitioner) assessed the patient. Facility staff did not assess and monitor R1's condition. R1 was not sent to the ER (Emergency	F 684			

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F 684	<p>Continued From page 14</p> <p>room) per the NP's directive until 8 hours later, by which time R1's condition had worsened, resulting in R1 being admitted to Hospital and passing away.</p> <p>Facility failure to recognize an acute change in condition, failure to closely monitor and assess a Resident with an acute change in condition, and failure to clarify verbal orders with the Nurse Practitioner, which resulted in a delay of treatment and alternative interventions at the hospital created a finding of Immediate Jeopardy that began on 12/4/20. Surveyor notified NHA A (Nursing Home Administrator), DON B (Director of Nursing) and RNC C (Regional Nurse Consultant) of the Immediate Jeopardy on 12/15/20 at 4:05 PM. The Immediate Jeopardy was removed on 12/15/20, however the deficient practice continues at a scope/severity of an E (potential for more than minimal harm/pattern) as the facility continues to implement its action/corrective plan.</p> <p>This is evidenced by:</p> <p>Example 1 Facility policy entitled 'Notification of Change' states in part: "...The resident's physician and responsible party must be notified when an event involving the resident occurs or when the resident experiences a change in condition, potential discharge, room transfer or death ...adopted the current INTERACT Tools change of condition. When to report to the MD/NP/PA (Medical Doctor/Nurse Practitioner/Physician Assistant) ...Assessment: 1. When made aware of a change in condition of a resident the licensed nurse will perform an assessment based on their professional judgement that may include: vital</p>	F 684			

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F 684	Continued From page 15 signs; mental status; major diagnosis (i.e. blood glucose check); allergies; current pertinent medications; recent pertinent lab work; pulse oximeter readings/O2 sats (oxygen saturation) as pertinent; skin inspection; bowel sounds as pertinent; lung sounds as pertinent; meal intake as pertinent; pain level as pertinent; voiced complaints by the resident if any; actions already taken; present of advance directives; utilization of critical pathways and change of condition as relevant; INTERACT care paths implemented. ...Planning: ...D ... speaks to the Physician/PA/NP utilizing SBAR (Situation, Background, Assessment, Recommendation) communication. Reference and follow INTERACT Care Paths and or change in condition reference tools as applicable ... Notify the Physician immediately if the resident requires immediate action. Call 911 in emergency situations: such as unconsciousness ...respiratory arrest, unresponsiveness ..." " Notification: 1. Call the Physician and document using the SBAR communication form and/or progress note. ...5. Notify the Director of Nursing of the residents condition change. 6. The licensed nurse is to provide frequent checks on the residents condition while waiting for a call back from the physician and or NP. Alert the direct care givers of residents condition change and signs and symptoms to be watching for. 6. Once the physician calls back, describe residents condition ... Document physician's orders and implement ... 10. Document the residents condition change and new orders on the 24 hr (hour) report log. Outcome evaluation: Monitor and reassess the residents status and response to interventions. The physician should develop a working diagnosis and guide nursing staff in what to look for, what to monitor for and when to re-contact	F 684			

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F 684	<p>Continued From page 16</p> <p>the physician if the residents progress deviates from the anticipated or expected course.</p> <p>Facility Policy entitled '2019 Novel Coronavirus (COVID-19)' states in part: "Increase monitoring of ill residents, including assessment of symptoms, vital signs and respiratory status to at least 3 times daily to identify and quickly manage serious infection and consider increasing monitoring of asymptomatic residents to at least every shift to more rapidly detect any with new symptoms. ...definitions: ...moderate illness: residents who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen less than or equal to 94% on room air. Severe illness: residents who have respiratory frequency greater than 30 breaths per minute oxygen saturation of less than 94% on room air (or, for patients with chronic hypoxemia, a decrease from baseline of greater than 3%) ..."</p> <p>On 12/15/20 at 10:00 AM Surveyor asked NHA A for the facility's INTERACT tools for respiratory changes and temperature changes, Surveyor was not provided any type of INTERACT tools or policy.</p> <p>R1 was admitted on 11/6/19 and has diagnoses that include COVID-19, Type 2 Diabetes Mellitus, Hypertension and Anxiety.</p> <p>R1's Annual MDS (Minimum Data Set) dated 11/9/20 indicates R1 has a BIMS (Brief Interview of Mental Status) of 10 out of 15 which indicates moderate cognitive impairment. R1 requires extensive physical assist of one for bed mobility and limited assist of one for transfers. R1 is indicated as being able to eat independently after</p>	F 684			

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F 684	<p>Continued From page 17</p> <p>setup. R1 is able to understand others and make herself understood.</p> <p>R1's PRN (as needed) Standing Order Form, signed on 11/26/19 by NP D (Nurse Practitioner), states in part: "18. O2 via nasal cannula as needed at 2-4L (liters) for O2 sats less than 90%.... Notify PCP (primary care provider) within 24 hours of decreased O2 sats ... 20 ...Notify provider for fever greater than 100 (degrees) or if symptoms not relieved in 3 days ..."</p> <p>There are no other Standing Order Forms signed by the NP or MD for R1 since 10/6/20 in R1's chart. Surveyor asked for R1's most current signed Monthly Physician Orders and received orders signed on 10/6/20 for 9/6/20-10/6/20.</p> <p>R1's Care Plan, dated 12/1/20, states in part: "Resident is positive or exhibiting signs and symptoms of COVID-19 infection. ...Approach: ... (12/1/20) administrator respiratory treatments as ordered [sic] ... Assess for any shortness of breath, apply oxygen per physicians orders, encourage resident to take deep breaths. Position resident to allow ease of breathing Assess vital signs every 4 hours. Record all vitals and report any changes to the physician. ...monitor for cough, frequency, changes...record and report any changes in mental status to physician ..."</p> <p>On 12/1/20, R1's Nurse Practitioner virtual visit note, states in part: "...recently diagnosed with COVID-10 [sic] as of today (12/1). She denies any acute concerns for me today. She denies cough, fever, chills, (shortness of breath), or chest pain, (nausea/vomiting), diarrhea. Staff do report poor appetite last day. She is more quiet/sleepy and lying in bed, which is outside her</p>	F 684			

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F 684	<p>Continued From page 18</p> <p>norm. Vitals reviewed and noted low grade temp of 99.1. ...Plan ... 2. COVID-19 positive. She appears to be doing well today. Mild low grade temp per NH chart. Will obtain baseline labs for monitoring. Repeat labs is decline [sic], worsening symptoms. Encouraged staff to push fluids ..."</p> <p>On 12/1/20 at 12:37 PM, R1's vital signs indicate a temperature of 99.1 degrees Fahrenheit with a O2 sat (oxygen saturation) of 95% without the use of oxygen.</p> <p>On 12/1/20 at 6:20 PM, R1's vital signs indicate a temperature of 99.6 degrees Fahrenheit with a O2 sat of 95% without the use of oxygen.</p> <p>On 12/1/20 at 11:59 PM, R1's vital signs indicate a temperature of 99.0 degrees Fahrenheit with a O2 sat of 95% without oxygen.</p> <p>On 12/2/20 at 4:15 PM, R1 had a temperature of 100.2 degrees Fahrenheit.</p> <p>Contrary to standing orders, there is no indication of R1's NP or Physician being updated on R1 having a temp. of 100.2 degrees at this time.</p> <p>On 12/2/20 at 8:53 PM, R1's vital signs indicate a temperature of 99.3 degrees with an O2 sat of 99% without the use of oxygen.</p> <p>On 12/3/20 at 11:41 AM, R1's vital signs indicate a temperature of 99.7 degrees Fahrenheit with an oxygen level of 95% without oxygen use.</p> <p>On 12/4/20 at 9:49 AM, R1's vital signs indicate a temperature of 98.3 degrees and O2 sat. of 92% without using oxygen.</p>	F 684			

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F 684	<p>Continued From page 19</p> <p>Per R1's care Plan R1's vitals are to be monitored every 4 hours, indicating R1's vitals would of needed to be checked at or around 1:49 PM, based on last vitals on day shift. There is no evidence R1 had her vital signs rechecked at or around 1:49 PM.</p> <p>On 12/4/20 at 1:35 PM, R1's Nurses Note, states in part: "Conts (continues) with isolation with proper PPE (personal protective equipment) in use. She has had no c/o (complaints of) pain, cough or SOB (shortness of breath). VSS (vital signs stable)."</p> <p>On 12/4/20 at 3:21 PM, R1's vital signs indicate a O2 sat. of 84% without using oxygen, a respiratory rate of 18, pulse/heart rate of 110 and a temperature of 98.4 degrees.</p> <p>R1's vital sign documentation indicates an acceptable pulse/heart rate of 50-100 beats per minute and an acceptable oxygen level of 90-100%. The facility did not notify NP or MD of change in R1's vital signs including a significant change in R1's increased heart rate and decreased oxygen saturation.</p> <p>On 12/4/20, R1's NP Visit Note, states in part: "Patient was recently seen via virtual visit on Monday. At that time, she was alert sitting up in wheelchair, she denied any acute concerns at that visit. Today, she is much more lethargic. She is not responsive to my presence. Staff are unaware this is a change. Nursing home notes reviewed: previous charted vitals today were WNL (within normal limits) was noted to have a temperature of a 100.2 yesterday. Today on rounds, I find her HR (heart rate) is 110, BP</p>	F 684			

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F 684	<p>Continued From page 20</p> <p>(blood pressure) 146/80, 84% on RA (room air). She is afebrile at 98.4 during rounds. ...general: the patient appears comfortable and in no acute distress. Resp: non-labored RRR (regular respiratory rate), no rales, rhonchi, wheezing, on room air, O2 sat 84% on RA. CV: (cardiovascular) HR tachycardic (high pulse), regular rhythm. Neuro: lethargic, unresponsive ... Plan when I came on rounds today, patient does not appear well. This is a change from visit I did virtually 3 days ago. She is quite lethargic, unresponsive, HR tachycardic, low oxygen sats at 84-86%, RN (Registered Nurse) unaware of change, but states it is a change. Staff are unable to tell me how long she has been like this. ..Both son and daughter tell me they were unaware she has COVID. RN updated that family would like patient sent to ER for further work up ... Electronically signed by (NP D) at 12/04/2020 at 4:36 PM CST."</p> <p>On 12/14/20 at 10:50 AM, Surveyor interviewed CNA G (Certified Nursing Assistant) regarding R1 on 12/4/20. CNA G indicated R1 would look at you and wouldn't talk or respond to you. CNA G indicated they repositioned R1 a lot that day and she would smile but wouldn't look at you. CNA G indicated that R1 was not eating well or drinking. CNA G indicated she worked the AM shift into the PM shift (6 AM to 6 PM) that day and R1 sounded like she was not having an easy time breathing. CNA G indicated they were told if O2 sats were low could go out, CNA G indicated R1's O2 sats were low, and the Nurse on the wing didn't seem to know what to do. CNA G indicated that R1 looked like she was trying harder to breathe than normal the whole 12 hours she was there and R1 did not have oxygen on. CNA G indicated the nurse told her to keep R1 sitting up to increase</p>	F 684			

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F 684	<p>Continued From page 21</p> <p>her oxygen. CNA G indicated that she could not get R1 to eat breakfast or lunch that day and that by supper time R1 couldn't handle anything. CNA G indicated R1 was sleeping all day, and would look at you but no response. CNA G indicated this was different for R1, as R1 was always talking. CNA G indicated she reported it to the AM nurse and to the PM Nurse as R1 was not doing well. CNA G indicated it was like R1 was looking through you.</p> <p>On 12/4/20 at 8:57 PM, R1's Nurses Note, states in part: "At start of shift resident was very lethargic. Vital signs were: Temp 98.4 Pulse 110 Resp 18 Oxygen 84%. [sic] Through out the shift fluids were given. 3 containers of apple juice 120 cc (cubic centimeters) each along with ½ (half) bottle of coke, a bottle of Gatorade and 120 cc of nutritional shake. Total intake of fluids this shift is over 600 cc. at this time of 2100 (9:00 PM) residents vitals are as follows: temp 98.0 Resp 18 Pulse 82 Oxygen 90%. Resident is also able to respond when spoken to and resident also gave herself fluid and appeared to be very thirsty. BP 140/80. Resident is resting comfortable with no complaints of pain or shortness of breath. Resident's breathing is deep and quiet, no crackles or wheezes. "</p> <p>It should be noted the Nurses Note indicates resident was very lethargic at the beginning of the shift. R1 had just received a visit from the NP with verbal orders given to send R1 to the hospital for further evaluation. Although the nurse documents the lethargy at the beginning of the shift there is no follow-up assessment with a RN, or contact with the NP or MD on this noted lethargy. R1's vitals were not re-checked until 9:00 PM according to R1's Nurses Note. There is</p>	F 684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	<p>Continued From page 22</p> <p>no indication of continued assessment or monitoring despite R1 noted to be lethargic at the beginning of the shift.</p> <p>On 12/14/20 at 1:50 PM, Surveyor interviewed CNA L regarding R1. CNA L indicated she worked 4:00 PM to 10:00 PM on 12/4/20 with R1. CNA L indicated that R1 had COVID-19 and was declining. CNA L indicated they were monitoring her O2 sats, but no interventions were put in place that she was aware of. CNA L indicated that R1 would go in and out of it, as sometimes she'd acknowledge us and respond at times and other times tired and not wanting to drink. CNA L indicated that this was not normal for R1. CNA L indicated that R1 was like that the whole shift. CNA L indicated she saw R1 on 12/1/20 and she didn't feel good that day, but wasn't lethargic and was responding, eating and drinking more than she was on the 4th, but was still out of it as she didn't feel good. CNA L indicated she cannot recall R1 having oxygen on. CNA L indicated that the NP did rounds on the hall on 12/4/20.</p> <p>On 12/4/20 at 11:50 PM, R1's vital signs indicate a O2 sat of 75% while resting and no use of oxygen. Respiratory rate of 16 breaths per minute, temperature of 98.1 and a blood pressure of 128/78.</p> <p>On 12/5/20 at 12:31 AM, R1's Nurses Note, states in part: "Upon assessment resident was delirious, non-verbal and non-responsive. Resident would open eyes, but did not maintain eye contact or acknowledge presence. Mental status change noted. VS taken BP: 134/44, P: 110 R 10, O2 75% on room air. LS (lung sounds) diminished in lower lobes. Resident is using accessory muscles to breath at this time, SOB</p>	F 684			

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F 684	<p>Continued From page 23</p> <p>noted, MD contacted as resident has had a change in mental status and is having respiratory failure at this time. New order received from Medical Director to send to ER for further eval and tx (evaluation and treatment), family notified unable to reach POA stated number is disconnected. Son (name) contacted and agreed with transfer to hospital. Ambulance arrived and departed facility at 0035 (12:35 AM). Report called to ER. Awaiting new orders at this time."</p> <p>On 12/14/20 at 11:40 AM, Surveyor interviewed RN H regarding R1. RN H indicated it was reported to her in report that R1 did not have a good afternoon and an aide came to RN H and reported around 11:00 or 11:30 PM on R1's condition and R1 was sent out around midnight. RN H indicated that R1 normally responds and wouldn't even talk to me. RN H indicated she tried a sternal rub and R1 opened her eyes and wouldn't say anything, wouldn't squeeze my hands. RN H indicated she'd never seen R1 like that. RN H indicated that R1 did not have oxygen on. RN H indicated she was unable to put on oxygen on R1 as there was no concentrators available as they were all broken and no portable oxygen tanks available. RN H indicated she did not see anything they could use for R1. RN G indicated there was no order from the Nurse Practitioner, so RN H called the Medical Director and received an order to send to ER. RN H indicated she was told R1 was fatigued and didn't seem herself and that fluids were pushed during PM shift. RN H indicated her assessment wasn't anything like what she was told in report.</p> <p>On 12/5/20 at 12:04 AM, R1's Physician Order indicates send to ER (emergency room) for further evaluation and treatment via ambulance</p>	F 684			

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F 684	<p>Continued From page 24 STAT (immediately).</p> <p>On 12/5/20 at 12:41 AM, R1's Hospital Note, states in part: "...brought by EMS (emergency medical services) from (Facility name) for evaluation. Report is that patient recently tested positive for COVID-19. Today, she has had altered mental status, and has not been as responsive as usual, as usually she is very talkative. She has also been hypoxic. It is unclear when exactly symptoms started ... there is a note from earlier today by (NP D), Nurse Practitioner, that confirmed that she had been hypoxic with decreased level of alertness throughout the day. ...Patient did test positive for COVID-19 on 12/01. The note does state that the family would like the patient sent to ER for further workup. That note was signed at 4:30 in the afternoon. It is unclear why the care center waited until 12:30 in the morning to send her to the ER. EMS reports that she was hypoxic on room air when they arrived. ...ED course: ...patient brought in by EMS. Placed on oxygen via non-rebreather to maintain O2 sats. greater than 92%. ...during ED course, she did say [sic] more awake and alert with oxygen in place. She is given IV fluids judiciously given her respiratory hypoxia with COVID-19. ... Clinical impression: 1. COVID-19 2. Acute Respiratory Failure with hypoxia ...3. Hyperglycemia (high blood sugar). "</p> <p>(A non-rebreather mask is a medical device that helps deliver oxygen in emergency situations. It consists of a face mask connected to a reservoir bag that is filled with a high concentration of oxygen.)</p> <p>On 12/9/20 at 4:08 PM, R1's Hospitalist Death Summary, states in part: "Admission Diagnoses:</p>	F 684			

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F 684	<p>Continued From page 25</p> <p>COVID Pneumonia ...HPI (History of Present Illness) ...positive COVID-19 test on 11/30/20 (exposed to roommate with positive test) had routine nursing home follow-up with (NP D's name) on 12/1/20 initially unlabored breathing in ... "mood pleasant - speech clear and intact" had repeat visit on 12/4/20 with significant change in status, very lethargic, not responsive to presence of NP (NP D) at virtual visit had temperature of 100.2 on 12/3/20. She was noted to be hypoxic and per NP (NP D's) note at 4:36 PM, recommended evaluation in ED (emergency department). ...(Ambulance Service) called to (Facility Name) and brought patient to ED at 0032 (12:32 AM) on 12/5/20 with significant hypoxia on RA (room air) and non-communicative, altered mental status. Patient unable to provide any history. ..Hospital CourseShe was hypoxic in the ER and required 12 L of oxygen on non-rebreather to maintain appropriate oxygenation. She was also tachycardic with new onset atrial fibrillation. ...poor prognosis immediately from her admission."</p> <p>Facility investigation on R1 signed by RNC C on 12/7/20 notes the following:</p> <p>RN F's statement states in part: " statement regarding interactions with (NP D's name) on 12/04/2020. This writer had been assisting (NP D) with her visit that afternoon. At around 4:30 PM, this writer and (NP D) were discussing (R1's) health status. At the time, NP D was attempting to contact the resident's family regarding their wishes for the resident in regards to hospitalization. Shortly afterwards, (NP D) related to me that the family would wish for the resident to be sent in "if the residents oxygen saturations were still in the 80's and she wasn't doing well." I</p>	F 684			

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F 684	<p>Continued From page 26</p> <p>relayed this to the nurse on the COVID unit (LPN E's name). She informed me that she would go and check on (R1) at that moment. I left the facility shortly after that time." (signed by RN F on 12/9/20)</p> <p>"Interview with (LPN E) completed. (LPN E) was keeping resident stabilized. This was a directive she received from (RN F). (RN F) reporting NP told her if residents condition worsened family wanted her to be sent to the ER. Multiple checks and interventions provided to the resident. Resident was able to consume (greater) 600 cc (cubic centimeters) of fluid. During her shift she attempted to contact POA (name) without success. Phone number disconnected. At the end of her shift, she was comfortable with resident's status. Condition improved. Report was given to the oncoming nurse" (RN H).</p> <p>RN H's statement, states in part: "Statement regarding (R1), I received report from Nurse (LPN E) about resident being lethargic on PM's, also that her pulse was 140 and that O2 sat was 84%. (LPN E) claimed she was dehydrated and had been pushing fluids. After asking (LPN E) if she called and notified the DR (Doctor) about the resident's current status she told me that the resident was stable and there was no need to wake the Dr. up. (LPN E) stated we had an order from (NP D) to send resident out if needed, however there was no order or progress note noted. Upon assessment of Resident I called (Physician name) our medical director for an order to send resident to the ER for further eval and tx (treatment) as she was critical. I never had any contact with (NP D). Ambulance came and took resident to hospital and resident was admitted to (hospital name)."</p>	F 684			

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F 684	Continued From page 27 NHA A's statement, states in part: "12/9/20 (NHA A's name) Friday 12/4/20. About 5 PM, approached by (RN F) (MDS) that (NP D) was "hot to trot." I talked to (NP D) as she was upset to fix it. NP D stated found patient unresponsive and tachycardic and sats 84%, proceeded to ask nurse (LPN E) how long she had been this way. Nurse replied "she didn't know." Then said nurse had an attitude with her. NP D advised another resident looked "rough," "Nurse response looked better than 3 days ago." NP D asked why she was not updated 3 days ago. (No) response given." NHA A's typed investigation time line for R1's events on 12/4/20, states in part: " On December 4, 2020 at approx. 5 PM, I was approached by (RN F), MDS informing me that (NP D), NP was hot to trot regarding her rounds today. Writer went down to see her to see what was going on. Writer introduced herself as the new administrator and asked what was going on? (NP D) asked for clarification and writer stated, "I heard you were upset with some things and I wanted to touch base." "(NP D) informed writer that during her rounds today she found (R1) unresponsive, tachycardic and her O2 sats at 84%. She stated she asked the nurse how long she had been like this and the nurse didn't know and unable to give her an answer. She stated she was sending her into the hospital for hypoxia ... December 7, 2020 ~ 11:30 am - writer stopped to check schedule on her way in and (RN H) was at the desk as well. (RN H) informed writer that (R1) was not sent out until after 10 PM on Friday due to decline in condition.December 8, 2020 ...2:26 PM - writer retrieved NP note from (hospital name) (computer system) dated	F 684			

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F 684	<p>Continued From page 28 12/4/2020"</p> <p>(NHA A's typed investigation indicates she was aware that R1 was to be sent to the emergency room on 12/4/20. R1 was not sent until after 12:30 AM the next morning.)</p> <p>On 12/9/20 at 11:16 AM, R1's Internal Clinic Message, states in part: "she states (NP D) saw the patient on 12/4. In the note, she recommended that patient be seen in ER. The note was signed at 4:30, and patient didn't present to ER until midnight. The patient is expected to pass away. They need to know why there was a delay in sending patient to the ER, and if this needs to be reported." NP D's reply at 11:41 PM, states in part: "...the delay was on the behalf of the care center. I saw the patient on rounds and requested transfer right away due to hypoxia, unresponsive. The family was notified per my note and requested transfer, I am not sure why there was such a delay in transfer and I was not made aware of the delay until this time ... (Signed by NP D)."</p> <p>On 12/14/20 at 1:10 PM, Surveyor interviewed NP D regarding R1. NP D indicated she saw R1 on 12/1/20 and R1 was looking fine. NP D indicated on the 4th, she came in to do rounds and did her own vitals and R1's oxygen was 84% and she was sleepy, lethargic and then was told she had a temperature of 100.2 the day before and I was not notified of this. NP D indicated she spoke with RN F, who indicated it was a change for R1. NP D indicated after she saw R1 she requested R1 be sent to the ER. NP D indicated she verbally gave an order and did not write an order. NP D indicated she told RN F that R1 needed to be sent out. NP D indicated she is aware that staff</p>	F 684			

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F 684	<p>Continued From page 29</p> <p>had a hard time getting a hold of R1's power of attorney. NP D indicated that R1's family requested she be sent in. NP D indicated she did not write any order for oxygen and has no idea if they started oxygen on R1, as it was her assumption the facility would transfer R1 right away. NP D indicated she left the COVID-19 unit and talked to a nurse, who said it was a change. NP D indicated she requested another set of vitals be completed and is unsure if those vitals were taken as they were not reported to NP D. NP D indicated she was told that R1 woke up and was eating. NP D indicated that staff should have called with R1's change of condition, as R1 had normal vitals documented and on her rounds she R1 had a O@ sat of 84%, unsure of facility staff's accuracy with taking vitals as they never know their patients conditions. NP D indicated that RN F told her she'd check on R1 herself and look at R1, and RN F never updated NP D. NP D indicated that R1 was to be sent out via 911 due to being hypoxic. NP D indicated that if she was notified when R1's change of condition occurred, it could have changed the outcome due to providing COVID-19 treatment sooner, but cannot say for sure. NP D indicated she did not receive a call indicating R1 was COVID-19 positive, didn't find out until doing a visit with R1. NP D indicated she was not notified of R1 having a temperature the day before either, NP D indicated if notifications would have occurred R1's treatment course could have been changed and treatment could have been more timely if staff would of notified with change of condition.</p> <p>On 12/14/20 at 2:04 PM, Surveyor interviewed RN F regarding R1. RN F indicated she was not the nurse on the unit, so she did not physically see R1 but heard she wasn't doing well and was</p>	F 684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	<p>Continued From page 30</p> <p>assisting the NP with questions. RN F indicated she tried to help the NP get a hold of R1's family and only able to go off of R1's condition based on what's in their electronic health record. RN F indicated that NP D was on the unit to see Residents. RN F indicated it was her understanding that NP D came to her and said if (R1) is till not doing well and her sats are low in the 80's, to send out. RN F indicated she went to the Nurse on the unit at the time and passed on the message verbally. RN F indicated she told the nurse face to face, through the barrier. RN F indicated she thinks NP D's communication should have been written as an order, and that it was not. RN F indicated they get written orders from providers and don't typically take orders. RN F indicated the nurse on the unit was told and she indicated she was going to check on her. RN F indicated she has no knowledge of an RN assessment being done. RN F indicated an RN assessment is to be done with a change of condition. RN F indicated that a change in mental status and decrease in oxygen saturation would be considered a change in condition and an RN assessment is to be completed.</p> <p>On 12/14/20 at 1:40 PM, Surveyor interviewed LPN E, who was R1's nurse on 12/4/20 regarding R1. LPN E indicated that R1 improved after receiving 600 ml (milliliters) of fluids and her oxygen saturation went up to 90%. LPN E indicated the last time she checked on R1 was around 9:45 PM and provided R1 with a few juices as she was completely dehydrated. LPN E indicated that R1 did not eat any food but R1 was improved as when she came onto her shift, R1's O2 sat was 84%. LPN E indicated the communication skills in the facility are lacking as they used to get shift report and now they no</p>	F 684			

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F 684	Continued From page 31 longer get a shift report due to a big plastic sheet barrier being up. LPN E indicated she did not know who was talking to her through the COVID-19 unit plastic barrier. LPN E indicated that she was told by someone through the COVID-19 barrier that if O2 sats (saturations) are down the NP authorized to send to ER. LPN E indicated she has no clue who she was speaking to through the barrier, who spoke with the NP or who provided the information to her. LPN E indicated she had no order to go by. LPN E indicated she is unable to say if R1 was to go in as she was told if the O2 saturation is down and does not improve to send in. LPN E indicated she did not clarify anything with NP D as R1 was improving and that LPN E's understanding was if she got worse to send her in. LPN E indicated she did not know they had an order to send her into the ER now. LPN E indicated that R1's oxygen saturation was at 84% when she got to the facility. LPN E indicated by having R1 at 30 degrees and having her drink fluids otherwise R1 was "laying there and out of it." LPN E indicated this was not R1's normal behavior, LPN E indicated R1 is usually in her wheelchair asking when she can go out to smoke and is an active person. LPN E indicated that R1's condition was a change from the last time she saw R1 a week prior. LPN E indicated they are limited on RN's and has no idea if an RN assessed R1 as there was no communication of an RN assessment or who would of done the RN assessment. LPN E indicated she did not see anyone on the unit. LPN E indicated she had no clue the NP was in the building as she never saw her. LPN E indicated she did not see any oxygen started on R1 and has no idea if anyone was notified of R1's 84% oxygen saturation.	F 684			

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F 684	<p>Continued From page 32</p> <p>On 12/14/20 at 3:45 PM, Surveyor interviewed NHA A and DON B regarding R1. DON B indicated they follow standards of practice (SOP) (did not specify what SOP when asked) . DON B indicated that if NP or MD is in house they are expected to write their own orders and sign them. DON B indicated that R1 was positive for COVID-19 on 11/30 and was updated on 12/1 during telehealth visit. DON B indicated that R1's POA was not updated due to number was not working, and attempted. DON B and NHA A did not reply when asked if NP was to be updated on 12/2 with R1's signs and symptoms with having a Temperature above 99.0 twice. DON B indicated it was not understood to be a verbal order that if she gets worse to send her in, viewed it as a communication and not an order. DON B indicated that staff are to call the DON or have an RN come down to assess to determine an improvement or decrease in status or with a change in condition. DON B indicated that the NP was in the facility and should have written the order herself, when asked if staff needed to write a verbal order. DON B indicated that all other MD's that come in write their own orders and enter them into the computer. DON B Indicated they are not able to get ahold of LPN E to interview her about what happened.</p> <p>Facility failure to recognize an acute change in condition, failure to closely monitor and assess a Resident with an acute change in condition, and failure to clarify verbal orders with the Nurse Practitioner resulted in a delay of treatment and alternative interventions created a finding of immediate Jeopardy. The Facility removed the jeopardy on 12/15/20 when it had completed the following:</p>	F 684			

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F 684	Continued From page 33 1) The affected resident no longer resides at the facility. 2) The facility will complete an audit to ensure no other residents are affected. 3) F684 audit notification of changes to ensure changes in condition have been identified & placed on the 24 hour report tool have been instituted. a. Audits will be completed daily x (times) 30 days and then weekly x 3 months and then as recommended by QAPI Committee. b. Educate licensed nursing staff on facility change in condition policy and procedure prior to next working shift. c. On 12/14/20 education being provided prior to next shift worked on change in condition & family/MD notification. d. Education will include how to document family/MD notification, recognizing change in condition - including vital signs, weight loss, new orders - including medications. Review of what a change in condition would be and documentation requirements. e. Facility attempted on numerous occasions to contact family re multiple situations. Unable due to phone unable to receive calls at the current time. 4) The following will commend immediately on 12/14/2020 and all dates forward: a. The Director of Nursing will review the facility progress notes via facility activity report. Records will be reviewed for proper procedure. b. The Nursing Home Administrator and Clinical team will review change in conditions daily. c. Education of license staff of recognizing change in condition and documentation d. Education of staff to update DON or RN designee with all change in condition. e. Education to providers related to writing own	F 684			

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F 684	Continued From page 34 orders when in the facility f. Education of licensed staff related to writing a verbal order/sending to provider for signature. 5) The facility will monitor its actions through: a. Audits will be conducted by the DON or designee on the facility activity report, 24 hour nurse board, facility activity reports. Nursing progress notes for change in condition procedure. Daily on-going. b. Audits will be conducted of change in conditions have been identified timely and notifications have been completed with family/MD. c. Audits will be conducted by DON or designees for change in conditions along with proper notification timely. Daily x's 30 days then weekly x's (times) 3 months and then reviewed at next QAPI meeting for recommendations. 6) Any negative findings will be corrected immediately and referred to QAPI for follow-up. 7) Administrator will monitor to ensure compliance.	F 684			
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident	F 692			

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F 692	<p>Continued From page 35 preferences indicate otherwise;</p> <p>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;</p> <p>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility did not ensure Residents maintained acceptable parameters of nutritional and hydration status for 1 of 3 Residents (R) out of a total sample of 15 Residents (R7).</p> <p>R7's nutritional needs were not monitored to ensure she was meeting her estimated daily fluid needs, when she had a change of condition that resulted in hospitalization.</p> <p>This is evidenced by: Facility Policy entitled 'Weight Monitoring,' dated 01/2019, states in part: "4. Procedure: Residents will be weighed monthly in a timely manner (at least by the 10th of each month). ...Nursing Services is responsible to obtain monthly weights on each resident. ...The results are given to the DON (Director of Nursing), designee or RD/CDM/RDT (Registered Dietitian/Certified Dietary Manager) for input into the computer."</p> <p>Facility Policy entitled 'Monthly and Weekly Weights,' states in part: "...8.3.1 Monthly and weekly weights. Monthly weights: conducted on residents whose weight has been stable from the time of admission to current. Weekly weights conducted on residents that: a. have experienced a significant weight loss\gain as indicated by the</p>	F 692			

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F 692	<p>Continued From page 36</p> <p>weight variance report. b. are newly admitted to the facility regardless of payer. c. are re-admitted to the facility. d. Have a gradual weight loss over a period of time. ...All monthly weights will be transcribed on the weight and vital sign form in the residents medical record ..."</p> <p>R7 was admitted to the facility on 10/10/20 with diagnoses that include Congested Heart Failure, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, and Chronic Kidney Disease Stage 4.</p> <p>R7's Admission MDS (Minimum Data Set) dated 10/15/20 indicates R7 has a BIMS (Brief Interview of Mental Status) of 14 out of 15 indicating R7 is cognitively intact. R7 needs one person physical assist with supervision for transfers and bed mobility. R7 is indicated as being able to eat independently after set up. Section K indicates R7 weighs 170 pounds and R7 has no difficulties with swallowing or chewing.</p> <p>R7 fell and fractured her hip on 10/27/20 and was hospitalized through 10/30/20 when R7 was re-admitted to the facility.</p> <p>R7's MDS dated 11/4/20 indicates R7 is now moderately cognitively impaired. R7 needs extensive two person physical assist with bed mobility and needs extensive assist of one for transfers. R7 is indicated as needing supervision with eating after setup. Section K indicates that R7 weighs 170 pounds and has no problems with swallowing or chewing indicated.</p> <p>There is no further documentation of R7's weight other than in R7's MDS assessments. There is no evidence that R7's weights are being monitored.</p>	F 692			

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F 692	Continued From page 37 R7's Nutrition Care Plan, edited on 11/10/20, states in part: " ... (at) Nutritional/hydration risk d/t (due to): DM (diabetes mellitus), Chronic back pain, GERD (gastro-esophageal regurgitation disorder) edema 1+ bilat. LE (1 plus edema to bilateral lower extremities), recent nailing of R (right) hip 11/2020, poor po (oral) intake upon return. Goal: (R7) will receive adequate nutrition/hydration. No s/s (signs/symptoms) signif (significant) wt (weight) loss, no s/s fluid imbalance, surgical wound will show improvement, edema to resolve by next review ... Approach: ...10/12/2020 Assist with meals as needed ... diet per doctors order: Regular w/sugar sub (with sugar substitute). ...10/12/2020 Diet provides > 1920 cc's (greater than 1920 cubic centimeters) of fluids per day. ...10/12/2020 encourage fluids @ bedside and with activities. ...honor likes/dislikes ... 10/12/20 monitor for signs & symptoms of fluid imbalance (i.e. swelling, shortness of breath, dry mucous membranes, dry skin, poor skin turgor). ...10/12/20 Monitor meal intake/record. ...10/12/20 offer substitutes if consumes <50% (less than 50 percent) of meals. ...10/12/20 weight every month and/or prn (as needed) notify MD of significant change ..." R7's care plan is not being followed as R7 has not been weighed monthly or as needed. On 11/17/20 at 4:24 PM, R7's Nutritional Assessment Note states in part: "Dietitian follow-up for skin. Surgical wound on hip and coccyx wound noted to show improvement. Meal acceptance is unpredictable with variable intakes of zero to 100% of meals without an evident pattern. Diet has been supplemented with mighty	F 692			

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F 692	<p>Continued From page 38</p> <p>shakes TID (three times a day) with meals, ...she also is provided with the ordered house supplement 90 ml QID (four times a day) ... estimated needs ...fluid need -1925 cc. no further additions recommended as needs are readily provided."</p> <p>On 11/21/20 at 5:20 PM, R7's Nurses Note states in part: "...Skin is warm, dry, pale, appetite good ..."</p> <p>R7's December 2020 Physician Orders provided to Surveyor indicate a general diet, 90 ml (milliliters) high protein supplement four times a day related to decreased intake (11/15/20) and mighty shake with meals three times a day related to decrease in intake (11/15/20).</p> <p>R7's December 2020 MAR/TAR (Medication Administration Record/Treatment Administration Record) provided to Surveyor has no documentation of R7 receiving any supplements or how much of the supplement R7 consumed. There is no documentation to show R7 even received the supplements per her Physician orders.</p> <p>On 12/1/20 R7's total fluid intake is indicated as 210 milliliters (ml). On 12/1/20 R7's meal intakes indicate R7 ate 26 -50% of breakfast and dinner. There is no documentation for lunch intake.</p> <p>On 12/2/20 R7's total fluid intake is indicated as 60 ml On 12/2/20 R7's meal intakes indicate R7 ate 51-75% of breakfast and 1-25% of lunch. There is no documentation for dinner intake.</p>	F 692			

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F 692	<p>Continued From page 39</p> <p>On 12/2/20 at 12:11 PM, R7's Nurses Note, states in part: "...Resident encouraged to drink fluids throughout shift due to no urine output on shift prior. Resident has been drinking adequate fluids today ..."</p> <p>Of note, per documentation R7 only had 60 ml of fluid intake.</p> <p>On 12/3/20 R7's total fluid intake is indicated as 120 ml. On 12/3/20 R7's meal intakes indicate R7 ate 1-25 % of breakfast. There is no documentation for lunch or dinner intake.</p> <p>On 12/4/20 R7's total fluid intake is indicated as 240 ml. On 12/4/20 R7's meal intakes indicate R7 ate 51 -75% of breakfast. There is no documentation for lunch or dinner intakes.</p> <p>On 12/5/20 R7's total fluid intake is indicated as 120 ml. On 12/5/20 R7's meal intakes indicate R7 ate 51-75% of breakfast and lunch. There is no documentation for dinner intake.</p> <p>On 12/6/20 R7 has no documentation of fluid intakes. On 12/6/20 R7's meal intakes have no documentation for breakfast, lunch or dinner.</p> <p>On 12/7/20 R7's total fluid intake is indicated as 360 ml. On 12/7/20 R7's meal intakes indicate R7 ate 26-50% of breakfast and lunch and 51-75% of dinner.</p> <p>On 12/8/20 and 12/9/20 R7 has no</p>	F 692			

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F 692	<p>Continued From page 40</p> <p>documentation of fluid intakes.</p> <p>On 12/8/20 R7's meal intakes indicate R7 ate 51-75% of breakfast, 76-100% of lunch, and there is no documentation of R7's dinner intake.</p> <p>On 12/9/20 R7 has no documentation of meal intakes for breakfast, lunch or dinner.</p> <p>On 12/9/20 at 9:00 AM, R7's Nurses Note, states in part: "MD (medical Doctor) update of positive COVID test from Monday. She is having mild confusion no other symptoms."</p> <p>R7 is indicated as having an infection due to COVID-19, which would increase R7's nutritional and fluid needs. R7 has had multiple days of decreased fluid intake and not meeting estimated needs. The facility did not update the MD of R7's decrease oral intake.</p> <p>On 12/10/20 R7's total fluid intake is indicated as 720 ml.</p> <p>On 12/10/20 R7's meal intakes indicate R7 ate 26-50% of breakfast, 1-25% of lunch and no documentation of dinner intake.</p> <p>On 12/11/20 at 9:49 PM, R7's Nurses Note states in part: "Resident remains in bed, decreased appetite, difficult to swallow medication, re-positioned every 2 (two) hours and prn (as needed) to increase comfort. VS WNL (vital signs within normal limits)."</p> <p>On 12/11/20 R7's total fluid intake is indicated as 360 ml.</p> <p>On 12/11/20 R7's meal intakes indicate R7 refused dinner. There is no documentation for breakfast or lunch intakes.</p>	F 692			

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F 692	<p>Continued From page 41</p> <p>On 12/12/20 R7 has no documentation of fluid intakes or documentation of meal intakes for breakfast, lunch or dinner.</p> <p>On 12/13/20 at 8:21 PM, R7's Nurses Note, written by an LPN (Licensed Practical Nurse), states in part: "writer notes swollen hardness to right upper jaw approximately 4.5 inch x 4.5 inch in size. MD notified N.N.O. (no new orders) at this time. However requests to be called in AM to set up Telehealth visit for 12/14/2020 for possible antibiotic dosing. Vitals remain stable afebrile (fever free). Denies pain/discomfort to site of swelling. ...Resident took all medication as ordered one at a time with moderate fluids. Appetite noted poor with 25% intake."</p> <p>(R7 has a potential site of infection to her right jaw area, which would increase R7's fluid and nutritional needs in order to fight off an infection R7 already has a COVID-19 infection.)</p> <p>On 12/13/20 R7's total fluid intake is indicated as 120 ml. On 12/13/20 R7's meal intakes indicate R7 refused dinner. No documentation of meal intakes for breakfast or lunch.</p> <p>On 12/14/20, R7's total Fluid intake is indicated as 250 ml. On 12/14/20, R7's meal intakes indicate R7 ate 1-25% of dinner. No documentation of meal intakes for lunch or breakfast.</p> <p>(There is no indication that a Medical Professional such as a Physician or a Registered Dietitian was updated on R7's change in intakes over the past few days.)</p>	F 692			

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F 692	<p>Continued From page 42</p> <p>On 12/15/20 at 4:25 AM R7's Nurses Note, written by a Licensed Practical Nurse, states in part: "...Resident noted with muscle guarding and facial grimacing prior to scheduled Tylenol dose as scheduled with positive effectiveness noted. Writer notes resident requires assist with meals and oral intake at this time. Medications were given crushed for comfort in applesauce resident tolerated well. Sips of water encouraged throughout night with total oral intake of 240 cc (cubic centimeters). Repositioning recommended r/t (related to) resident increase in staff assistance. ...will continue to monitor closely."</p> <p>(R7 is now experiencing pain, is requiring assist with meals and oral intake. There is no indication R7's MD was notified or updated.)</p> <p>On 12/15/20 at 8:20 AM, R7's Nurses Note, written by DON B, states in part: "Family notification: Call placed with update that she did have the swelling and that MD seen her yesterday and did not make any changes. Asked to return a call as this needed to be left in a message."</p> <p>R7 was not seen on 12/14/20 by a MD or any type of Medical Provider.</p> <p>On 12/15/20, R7's total fluid intake is indicated as 480 ml.</p> <p>On 12/15/20 R7's meal intakes indicate R7 ate 1-25% of breakfast, lunch and a morning snack.</p> <p>On 12/15/20 at 6:06 PM, R7's Nurses Note, written by RN N (Registered Nurse), states in part: "Resident vitals within normal limits this PM shift. Lung sounds diminished. Resident has had one medium void throughout AM shift and thus far none on PM shift. ...Resident's intake has</p>	F 692			

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F 692	<p>Continued From page 43</p> <p>been poor unless strongly encouraged and assisted by staff. Residents sister in law did come see her via window visit this early afternoon and brought chocolate ice cream which resident ate 75% of. Resident drank med pass (supplement) with early morning medication pass but declined the majority of this at lunch time and only had 25%. This PM shift resident is responding when addressed but quiet and minimal response. Is alert and orientated to person and time but attempt x 2 for correct place. Will continue to monitor resident frequently and reposition frequently. ...spoke with (MD M's name) nurse this afternoon in regards to resident condition and skin check. No new orders at this time and will plan to have meeting with (MD M) and resident tomorrow morning."</p> <p>There is no indication that MD M received this message regarding R7 from RN N.</p> <p>On 12/15/20 at 7:05 PM, R7's Nurses Note, written by RN N states in part: "Resident vital signs within normal limits but breathing is shallow. She is alert and orientated to self but states (hospital name) when asked of location and unable to determine time or date. Resident has facial grimacing present with any repositioning but unable to state where pain is. Responds very minimally to assessment questions by writer and unable to speak above a whisper. Called MD (name) to update on condition and MD ordered resident to be sent to ER (emergency room) and evaluated further ..."</p> <p>On 12/15/20 at 7:30 PM, R7's Emergency Department Notes, state in part: "Physical Exam: ...(Temp) (99 degrees Fahrenheit) (respirations) 36, (blood pressure) 182/97, (oxygen) 99% on</p>	F 692			

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F 692	<p>Continued From page 44</p> <p>room air ... weight (138 lb (pounds) 3.7 oz (ounces)). Physical exam: ...she is in acute distress. Appearance: she is ill-appearing. She is not toxic-appearing. Comments: Confused, delirious appearing. HENT (Head, Ears, Nose, and Throat): ...mouth: mucous membranes are dry. ...comments: dried blood on teeth and oral mucosa. Dry mucous membranes. Swollen, tender and erythematous (red) right parotid area. ...patient given IV (intravenous fluids) and 3 g (grams) of Unasyn (antibiotic) for suppurative parotitis. ...clinical impression: 1. Suppurative parotitis. (Infection of the salivary gland) 2. Altered mental status. 3. Dehydration."</p> <p>R7 is indicated as weighing 138 lbs on 11/4/20. The facility indicates in R7's MDS that R7 had weighed 170 lbs. This represents a 31.6 lb weight loss between 11/4/20's MDS information and being hospitalized which would indicate a 18.58% weight loss.)</p> <p>On 12/15/20 at 10:14 PM, R7's Nurses notes indicate that R7 was transferred to another Hospital.</p> <p>On 12/16/20 at 9:13 AM R7's Hospital General Medicine Progress Note, states in part: "she's been confused for the past 2.5 days, difficulty to swallow liquid and solid for 2 days. Swelling on her face was noted starting on 12/13. Severe sepsis due to suppurative parotitis, leading to encephalopathy, dysphagia, some grunting ..."</p> <p>On 12/16/20 at 1:47 PM, R7's Nurses Note states: "Resident admitted to (Hospital name) with Dx (diagnosis) of Dehydration and infection in right side of face."</p>	F 692			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 692	<p>Continued From page 45</p> <p>On 12/16/20 at 3:03 PM, R7's Physician Note, by MD M, states in part: " S: Scheduled nursing home visit via video conference under COVID quarantine. On Sunday 12/13/20, I was called by (Name of facility) nursing to report pt (patient) had swelling on the right side of her face. No fever or abnormal vitals. She was still able to speak, eat and drink. I instructed them to call the clinic first thing Monday morning to arrange a video conference so I could evaluate her face and determine if she needed antibiotics for possible dental or other infection. This was not done. On Wednesday I called at the time scheduled for our video visit, at which time I was informed the patient had been sent to the hospital last night, then transferred from (name of hospital) to (name of hospital). The charge nurse at (name of hospital) would not disclose much information ... but I was able to ascertain that the patient was admitted with dehydration, delirium and parotitis that required IV Abx (Intravenous antibiotics); she is not able to take PO's (by mouth). ... I then called patients POA (power of attorney), (name) who confirmed all of the above and also mentioned that the patients warfarin was being held because she was actively bleeding with even gentle touching of the gums and oral mucosa ..."</p> <p>On 12/17/20 at 11:03 AM, Email regarding Resident Care Concern states in part: "(Physician name) connected with me regarding a care concern for one of his patients. On Sunday nursing home staff called (physician name) to report a patient had swelling of the right face/cheek. He determined b/c (because) no fever so [sic] didn't think she needed to go to the ER. He instructed nursing home staff he couldn't make a diagnosis without seeing it; since he can't come in the nursing home, he instructed them to</p>	F 692			

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F 692	<p>Continued From page 46</p> <p>call him first thing Monday to make a video apt. (appointment) they didn't. Tuesday night she was taken to (hospital name) and transferred to (hospital name) for a nasty infection of the parotid gland in her right cheek. She's dehydrated, delirious, and may end up needing surgery ..."</p> <p>On 12/17/20 at 4:09 PM, R7's Nurses Note, states in part: "...Call placed to (hospital name) spoke with (name) RN. She does remain stable with improvement and less swelling. She does continue to have antibiotics for infection in parotid gland. Today did have a NG (nasogastric) tube placed as she is not taking in adequate nutrition ..."</p> <p>On 12/29/20 at 7:39 AM, Surveyor interviewed RN H regarding R7. RN H indicated that R7 had no signs and symptoms of infection. RN H indicated that R7 was assisted with meals especially when she was confused. RN H indicated a lot of the time R7 would not want to eat but would drink cold items when she had COVID.</p> <p>On 12/29/20 at 10:43 AM, Surveyor interviewed RN N (Registered Nurse) regarding R7. RN N indicated that R7 was at first taking sips of fluid and R7 had ice cream brought in for her. RN N indicated after that R7 could not drink without gurgling. RN N indicated R7 was sent to the ER due to changes in swallowing, change in mental status as R7 was not able to talk above a whisper and was not able to say where she was or what was going on. RN N indicated R7 was assisted with meals due to having a decrease in appetite and was accepting of assistance with meals.</p> <p>On 12/29/20 at 12:45 PM. Surveyor interviewed</p>	F 692			

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F 692	Continued From page 47 MD M (Medical Doctor) who is R7's Primary Care Provider (PCP). MD M indicated on 12/13 he was on call that day and had received a call from the Nursing Home. MD M indicated he was told R7 had swelling in her face. MD M indicated he told the nurse to call him first thing Monday (12/14/20) in order to see her. MD M indicated he was working 12/14 and did not receive a call and did not receive a video call. MD M indicated he was working Tuesday (12/15/20) and also did not receive a call from the NH (Nursing Home). MD M indicated on Wednesday (12/16/20) he called the NH and found out that R7 went to the Hospital. MD M indicated that R7 was in the hospital for a parotid gland infection to the right side of her face. MD M indicated that this can happen if it's blocked or due to dehydration. MD M indicated a parotid infection itself is not a problem if caught right away. MD M indicated that R7 had a significant infection and that R7 was not with it, was unable to swallow and unable to be orientated. MD M indicated that R7 passed away yesterday (12/28/20). MD M indicated it's was unexpected for R7 to pass away from a parotid gland infection. MD M stated "I'm sure she was dehydrated due to probably not eating or drinking from the infection." MD M and Surveyor reviewed R7's meal and fluid intakes. MD M indicated he was not notified of R7's decrease in meals or fluid intakes. MD M indicated he expects to be notified with a decrease in meal or fluid intake over three days. MD M indicated that a provider should have been contacted after three days maximum with a change in intakes. MD M indicated that a parotid gland infection would decrease the amount of moisture, but R7 would still have the other glands (other side of mouth and under tongue) to moisten her mouth. MD M indicated R7 had dry membranes at the hospital due to dehydration.	F 692			

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F 692	<p>Continued From page 48</p> <p>MD M reviewed R7's labs from the hospital and indicated her labs are better than expected, but at R7's baseline she's completely with it but a little fuzzy at times. MD M indicated that R7's outcome could have been different, if he had been able to see her two days sooner and R7 had been started on antibiotics sooner. MD M indicated he would expect to be notified with any changes from baseline. MD M indicated he gave an order to have them call on Monday and they did not call, which delayed R7's treatment. MD M indicated he never received a call with an update on R7's status or that she went to the hospital until he called the NH on 12/16/20.</p> <p>On 12/29/20 at 3:00 PM, Surveyor interviewed DON B regarding supplement and fluid intake documentation. DON B indicated that mighty shakes are documented in the meal intakes.</p> <p>On 12/29/20 at 3:10 PM, Surveyor interviewed DM R (Dietary Manager) regarding R7. DM R indicated in order to know if R7 was meeting her needs would be by looking at food and fluid intakes. DM R indicated that RD S is the Registered Dietician for R7. DM R looked at R7's fluid intakes and indicated based on the documentation you would not know if R7 is meeting her estimated fluid needs or not as DM R does not know if the fluid documentation includes daily room water or just meals. DM R indicated that all supplement intakes are added into the fluid intake each shift. DM R indicated she's unaware of the location for staff documentation for supplement intakes or mighty shake intakes. DM R indicated that CNA's document resident fluid and food intakes. DM R indicated there is nowhere for the intakes to flag, if there is a concern or change. DM R indicated the mighty</p>	F 692			

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F 692	<p>Continued From page 49</p> <p>shakes are provided from dietary.</p> <p>On 12/29/20 at 4:10 PM, Surveyor interviewed LPN O regarding R7. LPN O indicated CNA's would chart fluid intakes and that Nurses would chart what was given to them if they were under a push fluid order. LPN O indicated otherwise she does not chart water intake for medication pass unless they're on intake and output. LPN O indicated dietary keeps track of meal and fluid intakes.</p> <p>On 12/29/20 at 4:12 PM, Surveyor interviewed CNA P and CNA Q regarding R7 and fluid intake. CNA P and CNA Q both indicated they document fluids in their electronic computer system. CNA P and CNA Q both indicated there's an option to mark refusal/not taken, did not occur, not here as well as they amount received. CNA Q indicated water is passed on each shift. CNA Q indicated that all water pass and meal intake fluids are added up and charted together per shift.</p> <p>On 12/29/20 at 4:35 PM, Surveyor interviewed RD S regarding intakes and fluids for R7. RD S indicated fluids and calorie needs are estimated upon admission based on admitting diagnosis, their weight, heart problems or chronic kidney disease. RD S indicated based on his progress note for R7, that R7's needs would like up with 25 ml (milliliters) per kilogram due to R7 having CHF (congestive heart failure). RD S indicated that R7's estimated fluid needs are 1925 ml, which 80% would come from fluids and 20% would come from food intake. RD S indicated R7 would get approximately 400 ml from her food and would still need 1525 ml through fluid intake itself. RD S indicated that R7 gets med pass supplement of 120 ml three times a day (360 ml),</p>	F 692			

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F 692	Continued From page 50 and scheduled water pass of 120 ml three times a day (360 ml) resulting in 780 ml needed from all other fluids. RD S indicated he assumes R7 is being given her supplements and water, unless it's not documented. RD S indicated if fluids are to be given with medication pass it would be on the MAR (Medication Administration Record). RD S indicated that on 12/15 R7 had 480 ml of fluids, on 12/14 250 ml, on 12/13 120 ml, on 12/12 no fluid intake documented, on 12/11 360 ml and 12/10 600 ml of fluid, RD S indicated those amounts are not meeting R7's estimated fluid needs. RD S indicated meal and fluid intakes are used as a tool as there is little value to recoding all intakes unless using it to notice a change of condition. RD S indicated that if a CNA notices a decrease or change in urine it needs to be reported. RD S indicated that signs of dehydration would be dry mucous membranes, poor skin turgor, and a change in consciousness which can all determine inadequate fluids. RD S indicated he should have been notified as soon as staff noticed a change in intake habits. RD S indicated the RD is not responsible for monitoring accuracy of meal and fluid intake documentation. RD S indicated residents are to be weighed monthly unless there is a change in condition or decrease in intakes. RD S indicated that R7 does not have any weights recorded and is not aware of what the facility policy states.	F 692			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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	F 880			

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F 880	<p>Continued From page 51</p> <p>development and transmission of communicable diseases and infections.</p> <p>§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:</p> <p>§483.80(a)(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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: <ul style="list-style-type: none"> (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. 	F 880			

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F 880	<p>Continued From page 52</p> <p>(v) 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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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: Based on observation, interview, and record review, the facility did not establish and maintain an infection prevention and control program to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections, such as COVID-19 or establish an infection prevention and control program that includes a system for preventing, identifying, reporting, investigating, and controlling infections such as COVID-19 following accepted national standards. This has the potential to affect all 30 residents residing in the facility.</p> <p>RN H tested positive for COVID-19, was asymptomatic, and continued to work in the facility. RN H had the potential to work with</p>	F 880			

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F 880	<p>Continued From page 53</p> <p>non-infected residents as the only nurse in the facility for 5.5 hours during a night shift in the early morning hours of 12/16/20.</p> <p>CNA J tested positive for COVID-19 and returned to work in the facility just three days after experiencing her last symptoms, despite CDC (Center for Disease Control and Prevention) recommendations on isolation.</p> <p>This is evidenced by: The Wisconsin Department of Health Services issued the COVID-19 Health Alert #18: Resources for Health Departments to Support Quarantine and Isolation Requirements, which states, "Mandatory exclusion from work or school during the required period of isolation and quarantine is imperative if we are to be successful in slowing and ultimately stopping community spread of the SARS-CoV-2 virus. Any exemptions to the requirement of exclusion from work for quarantined individuals must be made on a case-by-case basis, and only for compelling public health or safety reasons." It also states, "It is generally not appropriate for any person to attend in-person school or work if they have been diagnosed with COVID-19 and are within their infectious period. Outside of crisis situations in selected health care settings, return to work should only be allowed when a person has met the criteria for discontinuation of isolation, which for most people is 10 days after the onset of symptoms or the date of a first positive test. The CDC has provided guidance describing contingency and crisis standards of practice to mitigate healthcare personnel staffing shortages. The Wisconsin Division of Quality Assurance has also provided guidance describing a variance request process, by which Nursing Homes and</p>	F 880			

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F 880	<p>Continued From page 54</p> <p>Immediate Care Facilities may propose to use COVID-19 positive staff, after all other staffing options have been exhausted."</p> <p>The facility's "Emergent Infectious Disease Plan" section containing Employer Considerations reads that "a. Management will consider its requirements under OSHA, state licensure, Equal Employment Opportunity Commission, American Disabilities Act and other state or federal laws in determining the precautions it will take to protect its residents. Protecting the residents and other employees shall be of paramount concern. Management shall take into account: i. The degree of frailty of the residents in the care center; ii. The likelihood of the infectious disease being transmitted to the residents and employees; iii. The method of spread of the disease (for example, through contact with bodily fluids, contaminated air, contaminated surfaces); iv. The precautions which can be taken to prevent the spread of the disease and v. Other relevant factors. b. Once these factors are considered, management will weigh its options and determine the extent to which exposed employees, or those who are showing signs of the infectious disease, must be precluded from contact with residents or other employees ... h. Permit employees to return to work when cleared by a licensed physician, however, additional precautions may be taken to protect the residents."</p> <p>According to the CDC, "Among adults, the risk for severe illness from COVID-19 increases with age, with older adults at highest risk. Severe illness means that the person with COVID-19 may require hospitalization, intensive care, or a ventilator to help them breathe, or they may even die ... In general, your risk of getting severely ill</p>	F 880			

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F 880	<p>Continued From page 55</p> <p>from COVID-19 increases as you get older. In fact, 8 out of 10 COVID-19-related deaths reported in the United States have been among adults aged 65 years and older." https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html#anchor_1606159374271</p> <p>The facility policy titled, "Emergency Preparedness Emergency Staffing," dated 6/2020 notes that "In the event that staff are not able to report to duty the Director of Operations will reach out to other [corporate affiliated] facilities within the region for staffing assistance and state or federally-designated health professionals."</p> <p>Example 1 On 12/7/20, as part of the routine facility-wide testing, RN H was tested for COVID-19. According to the Fulgent Genetics lab form, the positive result was reported at 9:26 PM Pacific Standard Time (7:26 PM Central Standard Time). RN H was asymptomatic, had worked a day shift (6:00 AM - 2:00 PM) on 12/8/20 and then returned for a night shift on 12/8/20 at 10:00 PM. The facility and RN H were not yet aware that RN H had tested positive at this time. RN H was the only nurse working in the facility from 10:00 PM on 12/8/20 until the day shift staff reported to work at 6:00 AM. On 12/15/20, RN H was scheduled to be the only NOC nurse in the building according to the facility's schedule/staff assignment sheet.</p> <p>On 12/16/20 at 7:10 AM, Surveyor spoke with RN H over the telephone. RN H indicated she worked on the COVID-19 unit on the night shift of 12/15/20 into the morning of 12/16/20. RN H stated that another nurse did work until 12:30 AM,</p>	F 880			

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F 880	<p>Continued From page 56</p> <p>but then RN H was the only nurse in the building until 6:00 AM when the day staff arrived. There were three CNAs (Certified Nursing Assistants) in the building, as well. RN H states that all tasks for non-COVID residents had been completed by the other nurse. RN H did indicated that had a non-COVID resident have a nursing need or an emergency, she would have been responsible for taking care of them during that time. RN H also indicated she has continued without symptoms since testing positive. Surveyor asked RN H when she was informed that she had tested positive for COVID-19. RN H states she found out on "Thursday," and Surveyor confirmed with her that the date was 12/10/20. RN H states she was on the COVID-19 unit that day and that NHA A (Nursing Home Administrator) came and told her. RN H stated that the instructions given to her at that time were that she could continue to work as long as she was asymptomatic, and she must work on the COVID-19 unit only.</p> <p>Example 2 On 12/14/20 at 4:05 PM, Surveyor asked DON B if the facility had any other COVID-19 positive staff working in the facility. DON B indicated that CNA J had a positive test result and this was her first day back to work. The facility's staff surveillance line list indicates CNA J's test was collected on 12/10/20, symptom onset date was 12/10/20 and included cough and myalgia (body ache). The Fulgent Genetic lab form indicates CNA J's specimen was collected on 12/11/20 and the positive result was reported on 12/12/20.</p> <p>On 12/15/20 at 9:50 AM, Surveyor spoke with CNA J on the phone. CNA J stated that when she left at the end of her shift on 12/9/20, she had symptoms of a stuffy nose/congestion, but did not</p>	F 880			

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F 880	<p>Continued From page 57</p> <p>indicate when those symptoms began. CNA J also indicated that her last symptoms were on 12/11/20 and described it to feel "like a normal head cold, like a stuffy nose and cough." CNA J informed Surveyor that she tested positive on 12/10/20. Surveyor asked who gave CNA J permission to return to work and CNA J stated, "My boss and the scheduler." CNA J stated her boss was DON B (Director of Nursing). CNA J also indicated that she was told that she would only work on the COVID-19 unit and after 10 days from testing positive she will be able to return to her "normal unit."</p> <p>According to CNA J's time card and the facility assignment sheet, she worked 16 hours on 12/9/20 (a day shift and PM shift) and she was working in the Southwest wing both shifts, the area of the facility with negative (non-infected) residents.</p> <p>Screen in logs provided by the facility indicated CNA J screened in with no fever on 12/8/20, but this information is written in below the provided chart space and is not clear if she indicated whether or not she had any symptoms at the time. The NHA A and Surveyor were unable to locate CNA J on the log in sheets for 12/9/20. According to CNA J's time card punches, she worked 9 hours on 12/14/20, after testing positive for COVID-19 and experiencing symptoms. On 12/15/20, CNA J came to work again on a PM shift and was listed on the assignment sheet to be working the COVID-19 unit.</p> <p>On 12/15/20 at 10:05 AM, Surveyor spoke with LPHN I (Local Public Health Nurse) who indicated that they had taken part in a RAST call (Rapid Assistance and Support Teams) with the facility</p>	F 880			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	<p>Continued From page 58</p> <p>on 12/3/20 and there was discussion regarding the potential of upcoming staffing concerns in the facility. LPHN I stated the facility was instructed to utilize WEAVR (Wisconsin Emergency Assistance Volunteer Registry) by submitting a request and to contact state if it appeared they were approaching critical staffing levels. LPHN I also stated that the facility did contact the local public health department again on or around 12/10/20 to inform them the facility was moving to crisis staffing mode and would need to schedule staff who have tested positive. LPHN I said she was not aware that the facility had not taken the previously recommended steps prior to COVID positive staff working in the building. LPHN I also stated that the recommendation would be that only asymptomatic positive staff could work, that they could only work with COVID positive residents, and they must wear full PPE the entire shift. LPHN I stated they would follow the Health Alert Network updates #18 and #22.</p> <p>On 12/15/20 at 8:54 AM, NHA A stated she had not submitted a WEAVR request. NHA A did submit a WEAVR request shortly after this interview.</p> <p>On 12/15/20 at 5:50 PM, Surveyor spoke with NHA A and DON B and asked who is responsible for ensuring an ill employee does not come to work? DON B replied, "That would probably be me." Surveyor asked what took place yesterday, 12/14/20, when CNA J reported to work. DON B stated, "She was not on the schedule. I didn't know she was coming in until I saw her here." DON B did not ask CNA J to leave the facility, and CNA J was allowed to stay and work on the COVID-19 unit. NHA A and DON B were aware that CNA J had reported to work for a PM shift</p>	F 880			

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NAME OF PROVIDER OR SUPPLIER TOMAH NURSING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 BUTTS AVE TOMAH, WI 54660		
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F 880	Continued From page 59 again on 12/15/20. CNA J was reportedly sent home by management in the late afternoon or early evening on 12/15/20.	F 880			