STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00324570. This visit resulted in an Immediate Jeopardy. Complaint IN00324570 - Substantiated. Federal/state deficiencies related to the allegations are cited at F880. Survey dates: April 15, 16, 17, 18 & 19, 2020 Facility number: 000048 Provider number: 155115 AIM number: 100275330 Census Bed Type: SNF/NF: 107 Total: 107 Census Payor Type: Medicare: 6 Medicaid: 99 Other: 2 Total: 107 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1 Quality Review completed on 4/24/2020.	F 0000	**The facility is requesting face to face IDR as we disagree with the scope and severity assigned to this deficiency.** **F880 – Infection Prevention & Control** It is the practice of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	
F 0880 SS=K Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (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: (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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on record review, interview and observation, the facility failed to follow CDC guidance during a pandemic and implement an infection control program for timely and accurate assessment of signs and symptoms of COVID-19, continued monitoring of symptoms and ensuring proper isolation requirements and testing were initiated timely to prevent the virus from spreading, for 15 of 15 residents reviewed for infection control (Residents H, J, D, E, B, C, F, K, L, M, N, Q, S, G, P). As of 4/15/2020, the facility had 39 confirmed COVID-19 cases, including 2 deaths and 2 currently in the hospital. On 4/15/2020, two residents (Residents M and N), who were in close contact with other residents positive for COVID-19, were moved	F 0880	**The facility is requesting face to face IDR as we disagree with the scope and severity assigned to this deficiency.** **F880 – Infection Prevention & Control** It is the practice of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	04/20/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	onto another unit into rooms with residents (Q and S) who had no signs or symptoms and no previous known contact with positive COVID-19 cases, Resident N then tested positive for COVID-19 on 4/17/2020, creating the increased risk of further spread of COVID-19 throughout the facility. The immediate jeopardy began on 3/26/2020 when multiple residents were exhibiting symptoms consistent with COVID-19 but were not monitored and/or isolated. The Corporate Nurse, Regional Vice President of Operations, Executive Director, and Director of Nursing were notified of the immediate jeopardy on 4/16/2020 at 1:35 p.m. The immediate jeopardy was removed on 4/19/2020, but noncompliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: During an interview, on 4/15/2020 at 1:30 P.M., the ED (Executive Director) indicated the facility had a total of 39 confirmed COVID-19 cases to date, including 2 deaths (one at the local hospital and one in the ambulance outside the facility) and 2 residents currently at the local hospital. She indicated Resident H expired in the ambulance in front of the building and Resident J had expired at the hospital. She indicated the hospital had contacted the facility on 4/11/2020 in regard to Residents H and J with concerns of a COVID-19 outbreak and wanted to complete testing in the facility. The local hospital and the local health department tested all residents on the first floor of the facility (North, East, West and Dementia units) on 4/12/2020. The ED		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident H – Resident discharged from the facility. Resident J – Resident discharged from the facility. Resident D – Remains in Isolation at the facility, respiratory status is being assessed and monitored every shift. Family and physician are aware of this resident's condition. Resident E – Resident discharged from the facility. Resident B – Resident discharged from the facility. Resident C – Resident remains in the facility; respiratory status is being assessed and monitored every shift. Family and physician are aware of this resident's current status. Resident F – Resident discharged from the facility. Resident K – Resident is currently not residing at the facility. Resident L – Remains in Isolation at the facility, respiratory status is being assessed and monitored every shift. Family and physician are aware of this resident's condition. Resident M – Resident remains in the facility; respiratory status is being assessed and monitored every shift. Family and physician	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the COVID-19 positive units were the dementia unit and north hall, and the east and west units were negative for COVID-19. The ED indicated the emergency plan for COVID-19 was implemented in the facility on 4/11/2020 with notification from the hospital that Resident J was positive; he expired on 4/13/2020 at the hospital. Review of the ISDH facility reporting tool as of 4/15/2020 indicated the facility had reported to ISDH the positive COVID-19 result for Resident J on 4/11/2020, but had not reported to ISDH the COVID-19-related deaths of Resident H or Resident J or any other residents positive for COVID-19. Review of an order signed by the State Health Commissioner, dated 4/08/2020, and included in the ISDH LTC (Long Term Care) Newsletter, dated 4/09/2020, included the requirement for COVID-19 reporting for long-term care facilities, prisons, jails, and other congregate housing. Effective Friday, April 10, 2020, long-term care facilities were required to report the following within 24 hours: Any resident who tests positive for COVID-19; Any employee who tests positive for COVID-19; Any confirmed positive COVID-19 related death OR suspected COVID-19 related death of a resident; Any confirmed positive COVID-19 related death OR suspected COVID-19 related death of an employee. Confirmed or suspected deaths should be reported regardless of where the death occurred and within 24 hours of the facilities' knowledge of the death. During an observation, on 4/15/2020 from 1:55 P.M. to 2:15 P.M., the north hall and the dementia unit were observed. The north unit was closed off with fire doors. The doors of residents' rooms were opened, and residents		are aware of this resident's current status. Resident N – Remains in Isolation at the facility, respiratory status is being assessed and monitored every shift. Family and physician are aware of this resident's condition. Resident Q - Resident remains in the facility; respiratory status is being assessed and monitored every shift. Family and physician are aware of this resident's current status. Resident S – Remains in Isolation at the facility, respiratory status is being assessed and monitored every shift. Family and physician are aware of this resident's condition. Resident G – Resident is currently not residing at the facility. Resident P - Resident remains in the facility. Family and physician are aware of this resident's current status. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. Facility wide Resident Assessments were completed by DNS and/or Nurse Management Team to determine any resident experiencing symptoms of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were observed in their rooms. Resident D and Resident F were observed lying in their beds. During this observation, RN 2 indicated all residents on this unit were positive for COVID-19 (total of 10), and there was one resident per room. She indicated Residents D and F were not doing well. The dementia unit was secured with fire doors, residents were observed wandering in the halls and many residents were in their rooms. The majority of the doors were open. Resident E's door was closed. During this observation, RN 3 indicated the staff was not aware of who was positive for COVID-19 and who was not. RN 3 indicated they were to treat everyone as if they were infected. During an interview, on 4/15/2020 at 2:15 P.M., the DON (Director of Nursing) indicated all residents on the dementia unit had tested positive for COVID-19 except for two (Residents M and N) who were being moved off the unit as of this day (24 residents positive with two currently at hospital for a total of 26). 1. The record for Resident M was reviewed on 4/16/2020 at 2:30 P.M. An infectious disease laboratory result, dated 4/14/2020, indicated Resident M had tested negative for COVID-19. A progress note, dated 4/14/2020 at 11:23 A.M., indicated the physician had been notified of the COVID-19 results. During an interview, on 4/15/2020 at 5:00 P.M., the ED (Executive Director) indicated Resident M was one of only two residents who did not test positive for COVID-19 on the dementia unit (all residents on the unit were tested on 4/12/2020). She indicated Resident M had been moved off		COVID-19. Any resident exhibiting signs and symptoms of COVID-19 were placed in droplet + Isolation per facility policy and relocated to a COVID positive hall/unit. Respiratory Assessments including lung sounds, oxygen saturation and temperature are being assessed and documented by licensed nurses every shift on all residents. Care plans have been reviewed and updated as appropriate for any resident who has tested positive for COVID-19 and/or are displaying symptoms related to COVID-19. PPE is available and utilized per Infection Control Guidelines. The Infection Control Surveillance Log and Respiratory Line Listing is being kept updated each day with changes in resident status and is monitored daily by the DNS/Designee. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A Nursing In-service was conducted on or before 4/17/20 by the DNS/designee. This in-service included review of the policy related to timely and accurate assessments of signs and symptoms of COVID-19, early identification and ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the dementia unit and had been placed in a room with a resident who was asymptomatic on a unit with no COVID-19 positive residents on 4/15/2020. She indicated she had been moved in with Resident Q on the first floor, West unit. Resident M was not isolated for 14 days after being in close contact with other residents who were symptomatic or had confirmed COVID-19. The resident had been exposed to her roommate who tested positive for COVID-19 and other residents on the dementia unit, for three days after being tested, from 4/12/2020 to 4/15/2020, when moved to the other room on another unit. 2. The record for Resident N was reviewed on 4/16/2020 at 2:45 P.M. An infectious disease laboratory result, dated 4/12/2020, indicated Resident N had tested negative for COVID-19. During an interview, on 4/15/2020 at 5:00 P.M., the ED (Executive Director) indicated Resident N was one of the only two residents who did not test positive for COVID-19 on the dementia unit. She indicated Resident N had been moved off the dementia unit and had been placed in a room with a resident who was asymptomatic on a unit with no COVID-19 positive residents on 4/15/2020. She indicated she had been moved in with Resident S on the first floor, East unit. Resident N was not isolated for 14 days after being in close contact with other residents who were symptomatic or had confirmed COVID-19. The resident had been exposed to her roommate who tested positive for COVID-19 and other residents on the dementia unit, for three days		monitoring of any resident experiencing a change in respiratory status including elevated temperature, cough and/or SOB and Isolation requirements. ED/DNS/Designee will conduct rounds each shift to ensure proper Isolation practices are in place, PPE is properly being utilized and Infection Control practices are in place. Any resident who will exhibit sign and symptoms of COVID 19 will be monitored by DNS/Designee and will be tested per physician's orders. Residents will be cohorted per symptoms and testing results per infection control protocols. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS/designee will be responsible for completing the QAPI Audit tool related to proper cleaning and disinfection of Isolation Rooms weekly for 4 weeks and monthly for 6 months. The DNS/designee will also be responsible for completing the QAPI Audit tool related to COVID-19 and Infection Control. If threshold of 90% is not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	after being tested, from 4/12/2020 to 4/15/2020, when moved to the other room on another unit. Review of an infectious disease laboratory result, dated 4/17/2020, indicated Resident N had tested positive for COVID-19. Resident N had been in the same room with Resident S on a COVID-19 negative unit for two days at this time. During an interview, on 4/18/2020 at 11:28 A.M., the ED indicated additional residents were tested on 4/17/20, and there were 17 more positive cases in the facility. Resident N was moved back to the dementia unit. During interview, on 4/19/2020 at 1:45 P.M., the ED indicated, after receiving the additional test results, the residents who tested negative on the first floor, but had been in close contact with residents who recently tested positive, were moved upstairs on 4/18/2020 to the third floor into rooms with roommates who were negative and had not been previously exposed. She indicated she did not have time, and they needed off the COVID-19 positive units. ISDH Guidance for out of hospital facilities, dated 3/17/2020 and included in the COVID-19 Toolkit for Long Term Care, which was provided to the facility by an ISDH LTC Surveyor on 3/26/2020, indicated the following: "Patients with close contact with a confirmed COVID-19 patient (e.g., roommate or infected staff without wearing PPE) should be isolated and follow 14 day self-monitoring guidelines outline by CDC https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-longterm-care-facilities.html. If they develop symptoms, and are confirmed or suspected to have COVID-19,		met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed:** Compliance date = 4/20/20.	

they should remain in isolation until at least 14 days after illness onset or 72 hours after resolution of fever, without use of antipyretic medication, and improvement in symptoms (e.g., cough) whichever is longer."

CDC's "Preparing for COVID-19: Long-term Care Facilities, Nursing Homes," included in the "COVID-19 Preparedness Checklist for Nursing Homes and other Long Term Care Settings" within the COVID-19 Toolkit for Long Term Care, which was provided to the facility on 3/26/2020, was accessed on 4/17/20 at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html and included the following: "Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, prioritize for testing, transfer to COVID-19 unit if positive).
Closely monitor roommates and other residents who may have been exposed to an individual with COVID-19 and, if possible, avoid placing unexposed residents into a shared space with them." The COVID-19 Toolkit for Long Term Care was updated and distributed again electronically on 4/03/2020, and the above information remained the same.

3. On 4/15/2020 at 4:30 p.m., review of the Surveillance Log of Resident Infections and Antibiotic Use, dated March 2020, indicated Resident B presented with temperature, cough, and congestion with chest x-ray indicating possible pneumonia, and Resident C presented with shortness of breath, decreased oxygenation, labored breathing, and unresponsive.

Review of the Surveillance Log of Resident Infections and Antibiotic Use, dated April 2020, indicated Resident D presented with a cough and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

fever, Resident E presented with a temperature, decreased oxygen saturation and diminished lung sounds, and Resident F presented with complaints of being weak and dizzy, shortness of breath and nonproductive cough.

The LTC Respiratory Surveillance Line Listing, dated 3/6/2020 to 4/8/2020, was reviewed at 4:34 P.M. on 4/16/2020. The line listing indicated 7 residents had presented with respiratory symptoms, myalgia (muscle aches) or fever. Resident P presented with fever, myalgia and labored breathing on 3/24/2020. Resident B presented with cough on 3/25/2020, per MD not testing for COVID-19. Resident G presented with fever and myalgia on 3/25/2020, with no documentation of testing. Resident C presented with cough and shortness of breath, no date indicated, COVID-19 test negative. Resident D presented with cough on 4/7/2020, per MD not tested for COVID-19. Resident E presented with a fever on 4/7/2020 and shortness of breath, per MD not tested for COVID-19. Resident J had symptom onset on 4/8/2020, but no specific symptoms were indicated.

These surveillance listings indicated several residents were presenting with symptoms consistent with COVID-19 between 3/24/2020 and 4/08/2020. Their records, as well as the records of four additional residents who developed symptoms after 4/08/2020, were reviewed.

The record for Resident B was reviewed on 4/15/2020 at 4:35 P.M. The diagnoses included, but were not limited to, pneumonia and diabetes mellitus. The resident resided on the first floor, west unit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

A progress note, dated 3/18/2020 at 3:10 P.M., indicated Resident B was admitted to the facility from a local hospital.

Documentation did not indicate the resident was isolated for 14 days following admission from a hospital.

A progress note, dated 3/24/2020 at 11:07 A.M., indicated Resident B presented with a temperature of 99.3 and cough. The physician was notified and an order for a chest x-ray was obtained.

No documentation was available to indicate the resident was placed in isolation on 3/24/2020.

A progress note, dated 3/25/2020 at 8:36 A.M., indicated Resident B's chest x-ray result was discussed with the physician, and the resident was placed in droplet isolation.

A progress note, dated 3/25/2020 at 3:50 P.M., indicated the facility had called the local State Agency epidemiology department at the request of the physician to review Resident B's symptoms. Epidemiology had indicated it was up to the physician to decide if COVID-19 testing should be completed.

A progress note, dated 3/26/2020 at 5:44 P.M., indicated Resident B had a new order to discontinue droplet precautions.

A progress note, dated 3/27/2020 at 12:33 A.M., indicated Resident B had an occasional cough noted.

A progress note, dated 3/28/2020 at 2:49 P.M., indicated Resident B had an occasional dry

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

cough.

A progress note, dated 3/30/2020, indicated Resident B had a nonproductive cough noted.

A progress note, dated 3/31/2020 at 11:44 A.M., indicated Resident B continued on antibiotic for upper respiratory infection.

A progress note, dated 4/7/2020 at 11:25 A.M., indicated Resident B was discharged home.

A review of the bed board from 4/1/2020 to 4/6/2020 indicated Resident B was in a room with a roommate.

During an interview, on 4/15/2020 at 4:20 P.M., the DON indicated COVID-19 testing had not been completed on residents that presented with symptoms, because the physician had not ordered the testing.

During an interview, on 4/15/2020 at 5:00 P.M., the ED indicated she was not aware of any residents who required COVID-19 testing prior to 4/12/2020. She indicated Resident B was admitted to the facility on 3/18/2020, and the 14-day quarantine on new admissions did not get implemented until 3/24/2020.

During an interview, on 4/16/2020 at 12:36 P.M., the resident's physician, who was also the facility's Medical Director, indicated Resident B had "potential" symptoms of COVID-19, and he had requested the facility to notify the local state agency. He indicated Resident B was not tested for COVID-19, because he was told residents had to be sent to the hospital for testing. He indicated Resident B was removed from droplet precaution isolation on 3/26/2020 when his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

chest x-ray indicated pneumonia.

CDC guidance, "Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19)," originally dated 3/04/2020 and last updated 3/24/2020, was accessed at https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html on 4/17/2020 and included the following:
"Clinicians should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Most patients with confirmed COVID-19 have developed fever and/or symptoms of acute respiratory illness (e.g., cough, difficulty breathing). Priorities for testing include: ...PRIORITY 2 Ensure that those who are at highest risk of complication of infection are rapidly identified and appropriately triaged: Patients in long-term care facilities with symptoms
Patients 65 years of age and older with symptoms
Patients with underlying conditions with symptoms."

Review of guidance from CMS, ISDH and CDC included the following: A CMS memo QSO-20-14-NH, dated 3/09/20, and included in ISDH LTC (Long Term Care) Newsletter, dated 3/11/20, included, "Facility staff should regularly monitor the CDC website for information and resources (links below). They should contact their local health department if they have questions or suspect a resident of a nursing home has COVID-19. Per CDC, prompt detection, triage and isolation of potentially infectious residents are essential to prevent unnecessary exposures among residents, healthcare personnel, and visitors at the facility. Therefore,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

facilities should continue to be vigilant in identifying any possible infected individuals. Facilities should consider frequent monitoring for potential symptoms of respiratory infection as needed throughout the day."

The guidance, dated 3/09/20, also included, "Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present. Also, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor, or returning to long-stay original room)."
Review of the ISDH LTC Newsletter registrants, indicated the facility's corporate Regional Vice President of Operations was registered and receiving the ISDH LTC Newsletters.

4. The record for Resident C was reviewed on 4/15/2020 at 4:45 P.M. The diagnoses included, but were not limited to, schizophrenia and chronic obstructive pulmonary disease (COPD). The resident resided on the first floor, east unit.

A progress note, dated 3/23/2020 at 3:22 P.M., indicated Resident C had complained of a sore throat and cough with green sputum noted.

A progress note, dated 3/25/2020 at 12:10 A.M., indicated Resident C had an occasional cough noted.

There was no documentation available for isolation precautions that were implemented or continued monitoring of these symptoms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

A progress note, dated 3/27/2020 at 10:03 A.M., indicated Resident C was noted to have difficulty breathing, difficult to arouse. Her oxygen saturation was less than 90% and she was started on oxygen at 2 liters, lung sounds were diminished to bilateral lower lobes.

A progress note, dated 3/27/2020 at 1:08 P.M., indicated Resident C's biox (oxygen saturation) dropped and she presented with tachycardia. A new order for duoneb (nebulizer treatment) was received and administered.

A progress note, dated 3/27/2020 at 3:04 P.M., indicated Resident C was verbally non-responsive and was on 3 liters of oxygen.

A progress note, dated 3/27/2020 at 3:33 P.M., indicated Resident C was sent out to the local hospital.

A progress note, dated 3/30/2020 at 12:22 P.M., indicated Resident C was admitted to the local hospital for acute respiratory failure.

A progress note, dated 3/31/2020 at 7:23 P.M., indicated Resident C was admitted back to facility with right lower lobe infiltrate (pneumonia).

There were multiple progress notes, dated 4/01/2020 through 4/12/2020, that indicated Resident C was non-compliant with the 14 day quarantine following hospitalization and had to be redirected back to her room multiple times.

5. The record for Resident D was reviewed on 4/15/2020 at 3:00 P.M. The diagnoses included, but were not limited to, COVID-19 acute respiratory disease and COPD (chronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	obstructive pulmonary disease). The resident resided on the North hall on the first floor. A progress note, dated 4/4/2020 at 11:19 A.M., indicated Resident D had received a new order for Tessalon Perle (cough medicine) 100 mg (milligrams) three times daily for 7 days and for fluticasone nasal spray (for nasal congestion). A progress note, dated 4/4/2020 at 8:30 P.M., indicated Resident D had broken the social distancing precaution and sat in the dining room with other residents playing Dominos. He had no signs or symptoms of respiratory infection, no cough or running nose. A progress note, dated 4/5/2020 at 9:34 P.M., indicated Resident D was non-compliant with social distancing and was in the dining room with other residents; none were wearing masks. A progress note, dated 4/7/2020 at 4:19 P.M., indicated Tessalon Perle was administered with positive effects. A nonproductive cough and hoarse voice was noted. A progress note, dated 4/7/2020 at 4:46 P.M., indicated a new order for chest x-ray. A physician order, dated 4/8/2020, indicated Resident D was placed in droplet isolation due to having an active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission related to fever and cough. A progress note, dated 4/9/2020 at 10:12 A.M., indicated Resident D was in droplet isolation precautions and had a temperature of 99.2.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

A progress note, dated 4/9/2020 at 4:11 P.M., indicated Resident D had elevated temperature and was noted to be perspiring.

A progress note, dated 4/9/2020 at 8:28 P.M., indicated Resident D had a temperature of 100.4 and was noncompliant with droplet isolation and social distancing.

A progress note, dated 4/11/2020 at 3:31 P.M., indicated a new order for doxycycline twice daily for 10 days for COPD exacerbation.

A progress note, dated 4/12/2020 at 1:55 P.M., indicated Resident D had a temperature of 101.4, and complained of not feeling well with lethargy noted. Lung sounds were diminished on the right and oxygen saturation was 87/88%.

An infectious disease lab result, dated 4/12/2020, indicated Resident D had COVID-19 detected. The physician was notified on 4/12/2020 at 7:00 P.M.

A progress note, dated 4/14/2020 at 3:40 P.M., indicated Resident D presented with poor appetite and oxygen saturation of 87%.

During an interview, on 4/16/2020 at 1:38 P.M., the DON indicated Resident D was not placed in droplet precautions on 4/4/2020 when symptoms of cough and nasal congestion were noted because he did not have a fever. She indicated it was the policy of the facility to inform the physician of signs and symptoms, and it was at the physician's discretion if the residents were placed in isolation.

During an observation, on 4/16/2020 at 2:20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

P.M., Resident D was lying in bed, asleep, with the door to the room open.

A review of the bed board from 4/4/2020 to 4/12/2020 indicated Resident D was in a room with a roommate.

The COVID-19 Toolkit for Long Term Care, which was provided to the facility on 3/26/2020, indicated all LTC facilities who have not already done so, need to use the CDC COVID-19 Preparedness Checklist for Nursing Homes and other Long Term Care Settings to prevent the spread of coronavirus in their facilities. This checklist included: "Identification and Management of Ill Residents: The facility has a process to identify and manage residents with symptoms of respiratory infection (e.g., cough, fever, sore throat) upon admission and daily during their stay in the facility which include implementation of appropriate Transmission-Based Precautions.
The facility has criteria and protocol for initiating active surveillance for respiratory infection among residents and healthcare personnel."

On 4/17/2020 at 5:00 P.M., the Corporate Nurse provided the COVID-19 Resident Policy (replaces interim COVID-19 policy), dated 3/16/2020 (revised 3/19/2020, 3/23/2020 & 4/3/2020), which indicated a resident with suspected or confirmed COVID-19 would be placed on Droplet Precautions and signs would be placed outside of the patient's door. Resident room placement would occur only under the direction of the IDT team and Infection Preventionist. The door should remain shut except when entering and exiting the room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	6. During an interview, on 4/15/2020 at 1:45 P.M., RN (Registered Nurse) 3 indicated Resident E was "not doing well." The record for Resident E was reviewed on 4/15/2020 at 3:45 P.M. The diagnoses included, but were not limited to, COVID-19 and dementia. Resident E was documented as a full code. The resident resided on the dementia unit on the first floor. A progress note, dated 4/7/2020 at 10:41 P.M., indicated Resident E had a fever of 102 and chest x ray was ordered. There was no documentation of any isolation precautions at this time. A progress note, dated 4/8/2020 at 12:41 P.M., indicated a new order was received to place Resident E in droplet isolation precautions. A progress note, dated 4/8/2020 at 2:15 P.M., indicated Resident E's chest x-ray results indicated multifocal bilateral pulmonary infiltrates. A progress note, dated 4/11/2020 at 5:38 P.M. indicated Resident E was observed on the bedroom floor near bathroom entrance and he was too weak to stand. An Infectious Disease lab result, dated 4/12/2020, indicated Resident E had COVID-19 detected. A progress note, dated 4/14/2020 at 11:14 A.M., indicated Resident E's oxygen saturation was 77% and he was placed on oxygen mask at 6 liters. A progress note, dated 4/14/2020 at 11:17 A.M.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

indicated Resident E's family was notified on 4/13/2020 that he was positive for COVID-19.

A progress note, dated 4/15/2020 at 2:44 P.M., indicated Resident E's pulse was 42 and biox was 77%. Head of bed was elevated and oxygen mask at 10 liters was applied.

A progress note, dated 4/16/2020 at 8:35 A.M., indicated Resident E was placed on a non-breather mask at 15 liters and oxygen saturation was 92-94%.

A progress note, dated 4/16/2020 at 1:18 P.M., indicated Resident E continued to be restless and oxygen saturation was 84% on 6 liters and resident was non-compliant with rebreather. Physician was notified and resident was send out to local hospital due to being a full code.

A history and physical, dated 4/16/2020, indicated Resident E had reportedly had a cough, congestion, and fever up to 102 since 4/8/2020. He continued to have progressive worsening, hypoxia requiring up to 6 liters of oxygen. He continued to have shortness of breath, progressive hypoxia and was restless. Upon admission he required 12 liters of oxygen on a non-rebreather mask.

The Emergency Room report, dated 4/16/2020, indicated the physician had spoken with power of attorney and Resident E was changed to a Do Not Resuscitate from a full code. Diagnosis was viral pneumonia secondary to COVID-19.

A discharge summary, dated 4/17/2020, indicated Resident E was admitted for respiratory failure on 4/16/2020. He did test positive for COVID-19 and currently resided in

nursing facility that had a severe outbreak of the virus. He was found to have pneumonitis versus possible pneumonia in the setting of COVID infection. Upon observation, patient was breathing very heavily using his abdominal muscles, he was unable to follow any commands and he was not alert. "Patient was actively dying." The Discharge summary, dated 4/17/2020, indicated Resident E expired at 11:38 A.M. and primary cause of death was SARS-COv2 (COVID-19) viral pneumonia.

A review of the bed board from 4/7/2020 indicated Resident E was in a room with a roommate; the other resident was moved out on 4/8/2020.

During an interview, on 4/15/2020 at 4:40 P.M., the resident's physician/Medical Director indicated he had been told the COVID-19 testing was not being completed in the facility, and he just found out that there was a task force that would come do the testing in the facility last week. He indicated if testing had been allowed in the facility, he would have tested Resident B and Resident E for sure. He indicated the facility had told him that residents had to be sent out to the hospital to be tested for COVID-19.

During an interview, on 4/15/2020 at 4:50 P.M., the DON indicated that it was the facility's policy to send residents to the hospital for testing; there were no tests completed in the facility prior to 4/12/2020.

Review of the ISDH LTC Newsletter, dated 3/18/2020, included information regarding LTC Strike Teams who would be going to facilities to provide PPE training, communicate risk mitigation strategies with essential staff and do

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	targeted COVID-19 test collection. The ISDH LTC Newsletter, dated 3/25/2020, included a COVID-19 Toolkit for facilities. A copy of this toolkit, as well as information for the LTC Newsletter, was provided to the facility by an ISDH LTC surveyor on 3/26/2020. This toolkit included information regarding the ISDH teams available to come into facilities to rapidly test residents and staff who are suspected of having COVID-19. It instructed facilities who have residents or providers who are symptomatic and need to be tested, to contact the COVID-19 Outbreak Response Logistics Coordinator and included contact information. The toolkit also included contact information at ISDH if the facility would like to discuss the need for testing at the facility or COVID-19 prevention such as PPE donning and doffing. 7. The record for Resident F was reviewed on 4/15/2020 at 3:50 P.M. The diagnoses included, but were not limited to, COVID-19 and COPD. The resident resided on the North hall on the first floor. A progress note, dated 4/12/2020 at 11:10 A.M., indicated Resident F was weak and dizzy with moist non-productive cough and complained of shortness of breath. His oxygen saturation was 86% and oxygen at 2 liters was applied. There was no documentation of droplet isolation precautions implemented with cough and complaints of shortness of breath. An Infectious Disease lab result, dated 4/12/2020, indicated Resident F had COVID-19 detected. There was no documentation of droplet isolation precautions implementation. A progress note,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dated 4/12/2020 at 4:05 P.M., indicated social service had notified a family member of possible room move. A progress note, dated 4/15/2020 at 1:03 P.M., indicated Resident F was on 4 liters of oxygen and complained of shortness of breath with labored breathing. A progress note, dated 4/15/2020 at 6:22 P.M., indicated Resident F had cough and labored breathing noted. He was using accessory muscles to breathe, mouth breathing with slight nasal flare when exhaling and complained of shortness of breath. Biox was 95% on 5 liters of oxygen. Physician was notified with orders to continue to monitor. Family was notified and wanted resident sent out to local emergency room if condition worsened. A progress note, dated 4/15/2020 at 10:02 P.M., indicated Resident F was sent to the local emergency room at 8:00 P.M. Resident had shrill cough and labored breathing noted and indicated he was having trouble breathing, using accessory muscles to breath. Oxygen was at 5 liters per nasal cannula, oxygen saturation was 91% and respirations were 44. A History and Physical, dated 4/15/2020, indicated Resident F had presented with respiratory status over the past 5 days and tested positive for COVID-19 at facility. He was unable to contribute any information as Resident F was breathing hard and not answering questions. Assessment indicated COVID pneumonia and now a health-associated pneumonia. Daughter was notified of prognosis and agreed to a Do Not Resuscitate-Do Not Intubate and that he will likely not have a good outcome.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

The ER Physician Report, dated 4/15/2020, indicated Resident F presented with breathing difficulty with onset 5 days ago. The course/duration of symptoms was constant. Degree at onset moderate. Degree at present severe. Present to ER with gradually worsening difficulty breathing, had already been diagnosed with COVID and now has bilateral infiltrates and working to breathe. The daughter was notified that given the situation and diminished likelihood that he would survive on a ventilator, she elected to make him a no code and no intubation.

The Discharge summary, dated 4/20/2020, indicated Resident F was found to be COVID positive when he came to the ER, and chest x-ray showed some patchy airspace disease in the mid to lower lungs that was suspicious for infiltrate. Unfortunately, his respiratory status did decline rapidly. He received high-flow oxygen and continued to deteriorate. The decision was made in line with the patient's family wishes that patient be made a DNR and on end of life care, comfort measures. Resident F succumbed to his medical illness and died on 4/19/2020 at 5:15 P.M. Final diagnosis included, but was not limited to, COVID viral pneumonia.

A review of the bed board from 4/12/2020 indicated Resident F was in a room with a roomma
te; the other resident was moved out on 4/13/2020.8. The record for Resident H was reviewed on 4/15/2020 at 4:00 P.M. The diagnoses included, but were not limited to, dementia and history of gastrointestinal bleed. The resident resided on the first floor, east unit.A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	progress note, dated 4/7/2020 at 6:01 P.M., indicated Resident H had confusion and restlessness noted. A progress note, dated 4/7/2020 at 9:50 P.M., indicated Resident H had an unwitnessed fall. Resident was restless and confused, difficult to redirect during shift.A progress note, dated 4/8/2020 at 6:11 A.M., indicated Resident H had been restless, getting up from wheelchair and walking without assistance.A progress note, dated 4/8/2020 at 10:11 A.M., indicated Resident H had a fall review, and the interdisciplinary team determined the root cause of the fall was restlessness and confusion. A progress note, dated 4/10/2020 at 2:24 P.M., indicated Resident H ate his breakfast and dinner in bed. He was anxious and trying to get out of bed, he was assisted back to bed and made comfortable. A progress note, dated 4/10/2020 at 9:58 P.M., indicated Resident H was placed in a wheelchair with two assist transfer because he had difficulty holding himself in an upright position on the side of the bed. Speech was slow and paced.There was no physician notification documented for change in condition.A progress note, dated 4/11/2020 at 8:53 P.M., indicated Resident H had a fall from bed to floor. He was assisted to recliner with Hoyer lift transfer.An edited progress note, dated 4/12/2020 at 6:35 A.M., indicated Resident H presented with confusion and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	restlessness, had productive cough with no fever noted, lung sounds had wheezing noted on assessment.There was no documentation of physician or family notification of Resident H's change in condition.A progress note, dated 4/12/2020 at 8:52 A.M., indicated Resident H was found non-responsive in room, 911 was initiated. Oxygen mask was applied at 15 liters.An Emergency Room Report, dated 4/12/2020, indicated Resident H was found unresponsive at the nursing home and 911 was activated. The paramedics completed the ACLS (advanced cardiac life support) protocol for about 35 minutes without response, and the code was called in the field. Cardiac arrest was called in the field, and he was brought to the emergency department because he had been placed in the ambulance prior to the code being called. A laboratory report, dated 4/12/2020, indicated Resident H was positive for COVID-19.During an interview, on 4/15/2020 at 4:00 P.M., the DON indicated Resident H was alert and oriented with slight confusion at times. She indicated she was not aware of the progress note from 4/10/2020 with noted decline in ability to hold himself upright.During an interview, on 4/15/2020 at 4:45 P.M., the resident's physician/facility Medical Director indicated that last he had seen Resident H was on 4/8/2020, and he had not been			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	notified about the increased weakness and confusion noted since 4/10/2020. A review of the bed board from 4/3/2020 to 4/12/2020 indicated Resident H was in a room with a roommate.9. The record for Resident J was reviewed on 4/15/2020 at 2:55 P.M. The diagnoses included vascular dementia and history of cerebral infarction. Resident J was a full code. The resident resided on the first floor dementia unit.A progress note, dated 4/1/2020 at 9:46 A.M., indicated Resident J had an unwitnessed fall, resident had a noted decline in food consumption and labs were to be drawn for potential change in condition.A progress note, dated 4/1/2020 at 1:23 P.M., indicated Resident J had stayed in bed all shift and refused care and meals.A progress note, dated 4/2/2020 at 10:34 P.M., indicated Resident J has stayed in bed all shift and refused care and meals.A progress note, dated 4/6/2020 at 1:48 P.M., indicated Resident J had stayed in bed all shift.A progress note, dated 4/7/2020 at 4:33 P.M., Resident J was very combative and restless despite redirection and attempts to calm him.There was no documentation available of physical assessments, including respiratory assessments, completed related to potential change in condition since 4/1/2020.A progress note, dated 4/9/2020 at 10:23 P.M., indicated resident J was sent to the local emergency room related to elevated labs. The ER			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Physician report, dated 4/10/2020, indicated Resident J presented to the emergency room from nursing home with altered mental status and abnormal labs. The EMS report indicated Resident J had been more altered over the past few days. The son had indicated Resident J was normally conversive but had been declining over the past two days. Physical exam indicated mild respiratory distress, tachypnea, febrile and mottled lower extremities. Resident J was tachycardic upon arrival with tachypnea and hypoxia in the high 80's. Rectal temperature was greater than 102.A discharge summary, dated 4/14/2020, indicated Resident J was admitted on 4/9/2020 and date of death was 4/13/2020. Final diagnoses included, but were not limited to, severe sepsis with lactic acidosis, leukocytosis, high fever and hypoxia, COVID-19 positive, acute renal failure with acute tubular necrosis and metabolic encephalopathy.The admission history indicated Resident J was brought to the emergency room from an extended care facility with fever and was encephalopathic on arrival. He was found to have markedly abnormal labs and COVID-19 detected. The hospital course indicated Resident J was placed on comfort measures on 4/10/2020, was kept comfortable and had a progressive decline. By 4/12/2020 he began to mottle in his extremities and he proceeded to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	death at 11:25 A.M. on 4/13/2020.A review of the bed board indicated Resident J was in a room by himself until 4/8/2020 when the roommate from Resident E's room was moved in, due to droplet precaution isolation requirements for Resident E.10. The record for Resident P was reviewed on 4/16/2020. The resident resided on the third floor. Progress notes, dated 3/24/2020 at 1:43 A.M., indicated Resident P had elevated temperature of 101 and biox 94% on 2 liters of oxygen. Contact isolation was implemented. Progress notes, dated 3/24/2020 at 3:00 A.M., indicated a temperature of 102, respirations 36, respirations rapid and shallow. The NP stated to give the resident a nebulizer treatment.The resident was then sent to the emergency room on 3/24/2020.Review of a hospital Discharge Summary, dated 3/31/2020, indicated Resident P had presented in ER with chief complaint of fever and change in mental status. His oxygen saturation was 76% on 2 liters of oxygen with a temperature of 101.7. Admission diagnosis indicated Resident P was a PUI (Person Under Investigation for COVID-19).11. The record for Resident G was reviewed on 4/16/2020. The resident resided on the third floor. A progress note, dated 3/25/2020 at 9:52 A.M., indicated Resident G presented with labored breathing, biox 88% and temp of 100.7. Lung sounds were clear but			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	nasopharyngeal congestion was noted. Resident was placed in droplet precautions.A progress note, dated 3/25/2020 at 3:45 P.M., indicated MD was notified of lab results (CBC, CMP) and requested ISDH be notified.A progress note, dated 3/25/2020 at 3:50 P.M., indicated a call was placed with ISDH for them to review resident's symptoms, and they stated that the MD determines the need for testing.A progress note, dated 3/25/2020 at 4:00 P.M., indicated MD was notified of ISDH stating they weren't determining the need for COVID-19 testing at this time. MD did not want resident sent to ER to determine the need for testing. He suspects diagnosis to be pneumonia.A progress note, dated 3/25/2020 at 9:35 P.M., indicated resident remained on isolation but once in a while came out of her room into the hallway.A progress note, dated 3/26/2020 at 9:37 P.M., indicated Resident G was non-compliant with isolation in room. She looked a bit confused and required redirection to her room on several times during shift.A progress note, dated 3/27/2020 at 8:11 A.M., indicated flu swab and RSV was negative. CXR was not indicative of pneumonia, resident remained afebrile. MD notified and droplet precautions were discontinued. A progress note, dated 4/1/2020 at 9:35 A.M., indicated Resident G required increased help with activities of daily			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	living. There were no notes available from 4/01/2020 to 4/12/2020.12. The record for Resident K was reviewed on 4/16/2020 at 3:00 P.M. The diagnoses included, but were not limited to, dementia and chronic obstructive pulmonary disease. Resident K was a documented as a full code and resided on the dementia unit.A progress note, dated 4/12/2020 at 9:04 A.M., indicated Resident K had a change in status with oxygen saturation at 69%, blood pressure 91/70 and heart rate of 107. There was a lack of documentation for this resident from 4/01/2020 through this note on 4/11/2020.An Emergency Room Report, dated 4/12/2020, indicated Resident K was found to be nearly completely unresponsive and with hypoventilation. Nursing had placed on 4 liters of nasal cannula and called 911. The paramedics placed Resident K on a nonrebreather mask and brought her immediately to the emergency department. Resident presented with ineffective respirations at about 40 breaths per minute, she was hypotensive and mottled to the mid abdomen. She was cold to touch on arrival. Physical examination indicated a heart rate of 150 with frequent VPCs (abnormal heart rhythm), blood pressure was 70/40. The extremities up to the mid abdomen, again, were mottled and very cold to touch. White count was 14.4, lactic acid 14.8. A triple lumen catheter was placed in right			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	femoral vein and she was intubated. As resuscitation continued, the mottling resolved, tachycardia resolved. A consultation note, dated 4/12/2020, indicated Resident K had a diagnosis of acute hypoxemic respiratory failure and was in COVID-19 isolation with possible exposure to a positive COVID-19 patient in nursing home. She was brought to the emergency room from nursing home with severe hypotension, decreased level of consciousness, and cardiac pulmonary arrest. When she arrived to the ICU she was severely hypoxemic, hypotensive, was intubated, and resuscitated with IV fluids.A laboratory result, dated 4/12/2020, indicated Resident K was positive for COVID-19.During an interview, 4/17/2020 at 2:55 P.M., the DON indicated there was no documentation available for Resident K from 4/1/2020 to 4/12/2020. 13. The record for Resident L was reviewed on 4/16/2020 at 3:15 P.M. The diagnoses included, but were not limited to, alcohol induced dementia and hypertension. The resident resided on the first floor dementia unit.A progress note, dated 4/11/2020 at 12:38 A.M., indicated Resident L had a witnessed fall in the hallway that resulted in a small laceration on the right side of her head, and she was ambulating backward when she fell.A progress note, dated 4/11/2020 at 6:45 P.M., indicated Resident L had an unwitnessed fall and hit			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	her head sustaining a laceration to the posterior scalp. She was sent to the local emergency room.The ER Physician report, dated 4/11/2020, indicated Resident L had staples applied to wound on her head.A laboratory result, dated 4/12/2020, indicated Resident L was positive for COVID-19.14. During an interview, on 4/16/2020 at 1:38 P.M., the DON indicated assessments were completed on residents daily that included monitoring temperatures and respiratory assessments. She indicated lung sounds, shortness of breath, cough and oxygen saturations were monitored.There was no documentation of daily monitoring of lung sounds, shortness of breath, cough or oxygen saturation available for most residents reviewed above.During an interview, on 4/17/2020 at 2:58 P.M., the DON indicated the facility was monitoring and documenting temperatures every shift and monitoring for changes in condition. She indicated if anyone would have had a change in condition noted, then lung sounds would be monitored. During an interview, on 4/17/2020 at 4:58 P.M., the DON indicated according to the Medical Director there was no suspected COVID-19 cases prior to 4/11/2020 when the facility was notified by the hospital of the positive COVID-19 test for Resident J. During an interview, on 4/16/2020 at 3:23 P.M., the Executive Director of Operations at the local hospital indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	he had contacted the facility on 4/11/2020 per the request of the hospital due to concern of a possible COVID-19 outbreak at the facility. He indicated the concern was brought to his attention after one patient who had arrived in the local emergency room had to be immediately intubated and another had died in route, and both had tested positive for COVID-19. He indicated the facility "seemed shocked" by the diagnosis of COVID-19 in these residents and reported to him that there were no residents that were symptomatic in the facility. He indicated that suspected COVID-19 cases should be kept in droplet isolation precautions to prevent the spread. He indicated COVID-19 cannot be ruled out without a test. He indicated that if a resident is showing signs of COVID-19, they should be tested. He indicated he had provided the facility with 60 swabs to complete testing and had recommended to the facility that they swab all residents on all floors. He indicated residents who tested negative but remained in close contact with COVID-19 positive residents still had the potential to become infected. During an interview, on 4/16/2020 at 4:00 P.M., the ED indicated she had not followed through with the recommendation of testing all residents in the facility. She indicated there was not enough manpower to test the residents, and there was no place to move them to if			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	they were positive. The ED confirmed the facility had received the COVID-19 Long Term Care Toolkit from an ISDH LTC Surveyor on 3/26/2020 and had also received it electronically.During an interview, on 4/17/2020 at 4:15 P.M., the Corporate Nurse indicated residents were discharged out of isolation per the policy on infection control. She provided the policy, and it did not contain any information on COVID-19.During an interview, on 4/17/2020 at 4:20 P.M., the DON indicated the facility would place residents in isolation based on the decision tree. A copy of the decision tree was requested and no decision tree was provided. During an interview, on 4/17/2020 at 4:53 P.M., the DON indicated there was no decision tree and indicated they were following the facility's COVID-19 policy for fever and respiratory symptoms.During an interview, on 4/18/2020 at 11:30 A.M., the DON indicated she was aware of the CDC guidance on discontinuing isolation precautions for COVID-19 suspected and COVID-19 positive residents. She indicated there were no residents presenting with suspected COVID-19 symptoms prior to 4/11/2020.During an interview, on 4/18/2020 at 11:28 A.M., the ED and DON indicated the facility infection control nurse had been out of work for over a week, she had called the DON on Saturday morning, 4/11/2020,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	because she was not feeling well, and she tested positive for COVID-19 on 4/16/2020.During an interview, on 4/18/2020 at 11:28 A.M., the ED indicated no staff had been tested for COVID-19 prior to 4/12/2020.The facility's LTC Respiratory Surveillance Line list indicated five staff members presented with symptoms between 3/06/2020 and 3/26/2020. The symptoms of staff members included fever, cough and myalgia. No other staff with symptoms were listed until 4/11/2020, then 13 additional staff with symptoms were listed between 4/11/2020 and 4/16/2020.Review of ISDH "COVID-19 Guidance for Healthcare Workers," dated 3/16/2020, and also included in the COVID-19 Toolkit for facilities provided to the facility on 3/26/2020, and in the LTC Newsletter, dated 3/25/2020, included the following: "If the healthcare worker begins to exhibit symptoms, such as cough, sore throat, fever or shortness of breath, they must be sent home for self-quarantine and testing immediately ... The Indiana State Department of Health has set up a dedicated provider telephone line that is available 24 hours a day, seven days a week." The phone number for the hotline for healthcare providers was included in this guidance.On 4/15/2020 at 5:12 P.M., the DON provided the COVID-19 Emergency Response Plan, dated 3/2020, and indicated this was the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	policy currently being followed by the facility. The policy indicated its purpose was to ensure timely and appropriate monitoring, care, and management of all symptomatic residents and staff, make all efforts possible to decrease the risk of transmission of the infection from person to person, ensure timely identification of all new cases and identify parameters for a facility to initiate a quarantine. All facility residents...would be assessed for the presence of COVID-19 symptoms (have developed fever and/or symptoms of respiratory illness). Any resident showing respiratory symptoms and/or fever will be placed in droplet isolation. (Symptomatic residents with unconfirmed COVID-19 should be placed in private room or cohorted with another resident presenting with the same symptoms). The facility would contact the local health department and/or the local state agency for further guidance. The attending physician and medical director would be notified of any resident with COVID-19 symptoms. These residents should remain in the facility if medically stable and only hospitalized if medically necessary or ordered by a physician. Notify all residents and responsible parties of the presence of COVID-19 in the facility...Asymptomatic residents who were in close contact with other residents who are symptomatic or have a confirmed COVID-19 will be confined to their			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	rooms for 14 days.On 4/15/2020 at 5:12 P.M., the DON provided the COVID-19 Resident Policy, dated 3/16/2020, and indicated this was the policy currently being followed by the facility. The policy indicated its purpose was to provide early detection and effective triage and isolation of potentially infectious residents to prevent unnecessary exposure among residents, healthcare personnel and visitors. Clinical records and infection control surveillance logs will be reviewed daily to identify changes in temperature and signs of respiratory illness to be reported to physician and for early identification for suspected COVID-19. Residents with suspected or confirmed with COVID-19 were to immediately be placed in private room with door closed. The door should remain shut except for when entering and exiting.On 4/17/2020 at 5:00 P.M., the Corporate Nurse provided the AMDA Recommendations for Screening of Residents Suspected of COVID-19, dated 3/18/2020, which indicated probable cause: any two of the common signs/symptoms - initiate contact and droplet precautions and possible case: any one of the common signs/symptoms and more than one of the less common signs/symptoms - initiate contact and droplet precautions. (Common signs and symptoms: fever greater than 100.0, cough and shortness of breath. Less			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	04/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	common signs and symptoms: confusion or change in mental status, muscle aches, headache, sore throat, chest pain, diarrhea, nausea and vomiting).The immediate jeopardy that began in 3/26/2020 was removed on 4/19/2020 when the facility tested all residents for COVID-19 and provided staff education on early detection, change in respiratory status and isolation precautions. Noncompliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because of the need to continue monitoring residents and completing tests, isolating or cohorting residents in accordance with CDC guidance, as well as continuing staff education that reflects CDC guidance for COVID-19. This Federal tag relates to complaint IN00324570.3.1-18(a)3.1-18(b)(1)			