STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE VILLA AT GREEN LAKE ESTATES	6470 ALDEN DR ORCHARD LAKE, MI 48324

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure staff donned appropriate Personal Protective Equipment (PPE) according to Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommendations resulting in the potential for the spread of COVID-19 among residents and staff caring for residents. Findings include: According to COVID-19 Long-Term Care Facility Guidance dated [DATE], 1. Nursing Homes should immediately ensure that they are complying with all CMS and CDC guidance related to Infection Control . 4. Long-term care facilities should ensure all staff are using appropriate PPE when they are interacting with patients and residents, to the extent PPE is available and per CDC guidance on conservation of PPE. For the duration of the state of emergency in their State, all long-term care facility personnel should wear a facemask while they are in the facility. Full PPE should be worn per CDC guidelines for the care of any resident with known or suspected COVID-19 per CDC guidance on conservation of PPE. If COVID-19 transmission occurs in the facility, healthcare personnel should wear full PPE for the care of all residents irrespective of COVID-19 [DIAGNOSES REDACTED]. During an observation of the laundry room at the facility on [DATE] at 12:25 PM, Laundry Aide (LA) E wore a surgical mask that was pulled down below her chin, not covering her nose and mouth. During an observation and interview on [DATE] at 1:30 PM, the DON/ICN donned an isolation gown, shoe covers, a face shield over a surgical mask and gloves obtained from a cart containing PPE that was situated outside the COVID-19 positive unit. The cart of PPE contained a supply of N-95 masks. The DON/ICN entered the COVID-19 positive unit and entered the room where a COVID-19 positive resident was living. Isolation gowns that appeared to have been worn were hanging on a coat rack in the corner of the resident's room. Additional unoccupied rooms on the unit were inspected and used isolation gowns were observed hanging on closet doors or on wardrobe doors. This observation suggested staff who worked on the COVID-19 positive unit inappropriately doffed and donned PPE increasing their risk for exposure to COVID-19 and cross contamination. None of the used PPE was labeled to indicate what staff used the PPE or how many times it had been used. Several used gowns and face shields were observed hanging on hooks or set on a table in a room on the COVID-19 positive unit dedicated to doffing PPE. No hand sanitizer or cleaning solution approved to disinfect surfaces from the COVID-19 virus was found. A bathroom next to the doffing room was dedicated to hand washing with soap and water. The DON/ICN reported the gowns should not be hanging in resident rooms and did not have an explanation for the multiple observations. The DON/ICN said she forgot to wear an N-95 mask before entering the COVID-19 unit. During an observation on [DATE] at 2:20 PM, an unknown staff person sitting at a desk near the entrance of the facility was wearing a surgical mask that had been pulled down under his chin, not covering his nose or mouth. During an interview that began at 11:45 AM, Corporate Nurse Consultant (CNC) A reported that all staff had been issued N-95 masks for use on the COVID-19 unit, along with a paper bag to store used N-95 masks in for re-use. CNC A did not explain why all staff were not donning full PPE for the care of all residents per CMS and CDC recommendations. The NHA reported that since the beginning of the COVID-19 pandemic, a total of 33 residents had been sickened with COVID-19, 7 of those residents died . The NHA also reported that 30 employees had been infected with COVID-19 since March, 2020.

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