STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235363	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE MANOR HEALTHCARE CENT	G 3201 BEECHER RD FLINT, MI 48532

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 accurately perform surveillance and analysis of collected infection control data resulting in the potential for unidentified trends and outbreaks of COVID-19 infections affecting all 99 residents and staff of the facility. Findings include: During the initial tour of the third floor, in the presence of the Nursing Home Administrator (NHA), on 4/28/2020, beginning at 9:50 AM, staff were observed wearing isolation gowns in the hallway, entering and leaving different rooms wearing the same gown. According to the facility Tool Kit B, dated 4/2/2020, page 18, under the heading of Gowns, a clean isolation gown was to be put on upon entry to the resident room or area and removed or discarded when exiting the resident room or care area. Disposable gowns should be discarded after use. Upon review of the infection control line listing and the summary report for March 2020, the line listing and the summary did not add up or match. According to the Society for Healthcare Epidemiology of America (SHEA) and the Association for Professionals in Infection Control (APIC) Guideline: Infection Prevention and Control in the Long-Term care Facility, published in 2008 in the publication Infection Control and Hospital Epidemiology, surveillance involves the systematic collection, consolidation, and analysis of data on Healthcare Associated Infections to be used in planning infection control efforts and education. On the line listing for the second floor, Resident #4 was listed for a Healthcare associated infection (HAI) or what was formerly called nosocomial, thrush/Yeast infection described as a white coating on her tongue beginning on March 26, 2020, the treatment was stated to be [MEDICATION NAME] suspension four times a day for five days. According to the pharmacy website Drugs.com, [MEDICATION NAME] is an oral antifungal used for the treatment of [REDACTED]. The next name entered on the line listing for the second floor for March 2020 was Resident #13, who was listed as having an upper respiratory tract infection (URI) that was marked as 'Not Infection and had been treated with the antibiotic [MEDICATION NAME] 250 milligrams (mg) twice a day from 3-6-20 until 3-18-20. The Director of Nursing (DON) was interviewed by telephone at 9:45 AM on 4/30/2020, she stated that resident #13 had received an influenza vaccination two to three days before the entry was made and it was suspected the signs and symptoms were a side effect of the vaccine, not an infection. However, the entry was listed on the bottom of the page titled Healthcare Associated Infections Summary Report by Resident Days under Lower respiratory tract ([MEDICAL CONDITION] or [MEDICAL CONDITION]) - URI. The next name entered on the line listing for the second floor for March 2020 was Resident #14, who was listed as having a Skin infection with purulent drainage (pus) from the scrotal are and penis and had been treated with the antibiotic Keflex 500 mg three times a day for seven days from 3-28-20 until 4-3-20. There was no checkmark in the boxes labeled *Not Infection, HAI, or CAI (community acquired infection). When the DON was asked about there not being a checkmark in any of the boxes, she stated it was an oversight and added that she had not completed the line listing or the summary, those had been done by a Registered Nurse (RN), M from the corporate level, who no longer worked for the company. The last entry on the line listing was for Resident # 15, who had been listed for fungal/yeast rash from the Skin Assessment Documentation and had been treated with [MEDICATION NAME] powder daily for 14 days from 3--20 until 3-23-20. Her box had been checked as Not Infection. The DON was asked why her box had been checked for Not Infection, and she stated that Resident #15 had not met the criteria for an infection. The DON stated that the facility used the McGeer's criteria for infections. The Healthcare Associated Infections Summary Report by Resident Days listed the following numbers for the second floor, one for URI, and two for Fungal, which did not match the Line Listing of Resident Infections for the second floor for March 2020, which only had Resident #4 marked for a Healthcare Associated Infection for a Thrush/yeast infection. when the DON was asked about the inconsistency, she stated that it was incorrect documentation on the summary report. The first entry on the line listing for the third floor for March 2020 was Resident #8, listed as [MEDICAL CONDITION] or an eye infection, with red conjunctiva and positive drainage, treated [MEDICATION NAME] drops three times a day for five days, no dates entered for the treatment, instead of dates, the entry listed Hospice and no boxes were checked for the infection type, Not Infection, HAI or CAI. When the DON was asked, she looked up documentation and stated, It looks like community acquired, he was admitted with eye drops. The admitted for Resident #4 was listed as 2-7-20 on the line listing form. he DON stated she had to check the documentation for each resident as she answered questions because RN M had completed the forms and she, as the DON, was not as familiar with the responses coded for each entry. When the DON was informed that the line listing and summary portion of the forms did not match, she agreed that there was incorrect documentation on the report. The line listing for the third floor for March 2020 included Resident #7, who was listed as having a urinary tract infection [MEDICAL CONDITION], with the response urinalysis on 3/9/2020, in the column for Cultures:Date/Site/Results, in the column for treatment was listed [MEDICATION NAME] 500 mg twice a day for seven days from 3-14-20 until 3-21-20. This entry was not checked in the columns for Not infection, HAI or CAI. the symptoms were listed as unknown. This infection was listed on the summary report for the third floor, for UTI. There was no information about the culture result so it was unknown if the treatment of [REDACTED].#7 was sent back to the facility with the prescription for the antibiotic [MEDICATION NAME]. The DON believed that a staff member in the facility admissions department had computer access to the hospital lab results and would be able to obtain a copy of the urinalysis results that were performed at the hospital for the facility residents that were sent there for treatment and evaluation. The Summary Report for March 2020, stated No trends noted under the section for Specific Trends and there was nothing listed under Actions Taken. There was no documentation of how the rate of infections compared to the rate of the previous months, or interventions, such as staff education on handwashing, had been given The facility began giving education to its staff about coronavirus on 3/5/2020. Updates on coronavirus education to the staff occurred on 3/18/2020, 3/23/2020, 3/24/2020, 3/25/2020, and 4/20/2020. Resident #2 According to the Admission Record, printed on 4/28/2020, Resident #2 was a [AGE] year old male admitted to the facility on [DATE], and readmitted on [DATE] with [DIAGNOSES REDACTED]. According to the progress notes, on 4/5/2020, Resident #2 was sent to the emergency room with respiratory distress, was unable to keep his blood oxygen level above 92% without using a facemask for supplemental oxygen of 6 liters per minute and a cough productive of purulent mucous. The nurse documented that it may be too much medication or other respiratory disorder - on unit where residents have tested positive for COVID 19. Resident #2's temperature was documented as 99.4 degrees and his respiratory rate was 20 breaths per minute. According to the hospital documents, Resident #2 had been diagnosed with [REDACTED]. There was an entry on the April 2020 line listing for Resident #2 that indicated he had a urinary tract infection with no signs or symptoms, marked as No Infection with no urinalysis obtained for testing. According to the facility's Tool Kit B, dated 4/2/2020, The immediate response to the COVID-19 outbreak is one of infection containment and prevention. Regarding the management of a resident suspected of having COVID-19 the resident was to have their movement limited by having them remain in a private room and closing the door. Initiate droplet transmission-based precautions and post appropriate signage. In the section titled, Care Considerations, was the following statement Residents who are suspected of having COVID-19 infection are considered positive until testing confirms otherwise. The instructions were to Note in the medical record when the resident's first symptoms appeared, as well as when the resident was placed on Transmission Based Precautions. Resident #2 had no progress note stating that he had been placed

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235363	A. BUILDING _____ B. WING _____	**04/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE MANOR HEALTHCARE CENT	**G 3201 BEECHER RD FLINT, MI 48532**

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	(continued... from page 1) on isolation precautions, even though the progress note indicated that the nurse who documented was suspicious of the COVID - 19 infection as she had mentioned it in the documentation that was sent with Resident #2 to the hospital emergency roiagnom on [DATE]. On 4/8/2020 at 8:43 AM, Resident #2 was sent back to the hospital emergency room because he had a change in condition described as lethargic with altered mental status and respiratory distress, oxygen saturation at 83% with 5 liters of oxygen via a nasal cannula. His temperature was recorded as 99.5 degrees, axillary, and he continued to have a productive cough. Resident #2 was on the facility list of positive COVID - 19 residents with a date of the positive test listed as 4/8/2020. There was no indication that he had ever been placed on transmission-based precautions for COVID -19. A care plan related to a positive screening for COVID-19 was initiated on 4/8/2020, with the intervention of transmission-based precautions, after Resident #2 had been sent to the hospital for the second time. Resident #7 On 4/30/2020 at approximately 9:00 AM, a review was completed of Resident #7's medical records and is revealed the resident was a [AGE] year old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review was completed of Resident #7's progress notes, care plan and SBAR's (Situation, Background, Assessment and Recommendation) and it showed the following: SBAR dated 4/24/2020 at 3:46 PM - Temp 100.6, Resp-26, lethargic, poor diet, spo2-87-91%ra (room air) .I think the problem may be: GI infection, dehydration, respiratory . Per the SBAR the resident was transferred to the emergency room for further treatment and evaluation. 4/25/2020 at 3:32 AM: - Resident returned from hospital around 9 PM via emt (emergency medical transportation). [DIAGNOSES REDACTED].Once in room temp 101.7 given Tylenol for fever . 4/25/2020 at 7:24 PM: - Res (resident) encouraged to drink water, ice water at bedside, cool wash cloths applied to forehead. 4/26/2020 at 1:30 PM: - Res (Resident) discharged to ******* facility, vital signed wdl, meds sent with resident . Care Plan: Focus: I have restricted visitation secondary to COVID-19 precautions. Interventions: Provide additional reading materials-Provide alternative method of communicating with family, friend - Provide in room activities. Review was completed of the Discharge Summary (Patient Copy) and Triage Report from the emergency room was completed. It showed the resident was tested for COVID-19 and the results were pending. These documents were sent back to the facility with the resident on 4/24/2020 and the resident was never placed in isolation. Resident #7 was transferred from the facility on 4/26/2020. For two days, facility staff were providing care for this resident with a pending COVID-19 test, that was later confirmed as positive. Discharge Summary (Patient Copy) - UTI Male Fever in adults- Coronavirus testing should be done in 24-48 hours . Triage Report 2 - .pt (patient) had a fever at the facility, hasn't had an appetite. Cough . The progress notes and emergency room report show there were concerns. On 4/30/2020 at approximately 10:30 AM, a review was completed of Resident #7 laboratory results, it showed on 4/24/2020 at 7:48 PM, Resident #7 was tested for COVID 19 Virus while at the emergency room . The results were available on 4/25/2020 at 12:11 PM and revealed the resident was positive for COVID-19. From the facility's progress notes it is not clear when they were aware Resident #7 was positive for COVID-19. There was no mention of placing Resident #7 on isolation when he returned from the emergency room or any documentation regarding him being tested for COVID-19. Resident 11 According to the Admission Record, printed on 4/30/2020, Resident #11 was a [AGE] year old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The April Medication Administration Record [REDACTED]. On 4/21/2020 the 7:00 AM monitoring revealed that Resident #11 had spiked a temperature of 100.1 degrees and her oxygen saturation had dropped to 87%. There was no corresponding nurses note related to a respiratory assessment or evaluation of other signs and symptoms, such as sore throat, body aches, cough, lung sounds, or tiredness. The documentation on the April 21, 2020 MAR for 11:00 PM revealed that Resident #11's temperature was 99 degrees and her oxygen saturation was 90%. On 4/21/2020, the April MAR indicated [REDACTED]. There was a nursing progress note at 10:49 AM on 4/21/2020, that reported, Resident #11 just doesn't feel well and showed some signs of weakness. Resident #11 stated that she was short of breath at times and had a mild cough. the physician ordered Tylenol and to continue monitoring. At 2:17 PM, the physician called the facility to order further testing and evaluation at the hospital for COVID. On 4/22/2020, at the hospital, Resident #11 tested positive for COVID-19. According to the facility's Tool Kit B, dated 4/2/2020, The immediate response to the COVID-19 outbreak is one of infection containment and prevention. Regarding the management of a resident suspected of having COVID-19 the resident was to have their movement limited by having them remain in a private room and closing the door. Initiate droplet transmission based precautions and post appropriate signage. In the section titled, Care Considerations, was the following statement Residents who are suspected of having COVID-19 infection are considered positive until testing confirms otherwise. The instructions were to Note in the medical record when the resident's first symptoms appeared, as well as when the resident was placed on Transmission Based Precautions. Resident #11 had no progress note stating that she had been placed on isolation precautions.