STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235369	A. BUILDING _____ B. WING _____	09/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARWOOD MANOR NURSING HOME	**1300 BEARD ST PORT HURON, MI 48060**

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 -** Few	**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 properly maintain infection control practices during a COVID-19 (a potentially life threatening respiratory virus) Infection Control Survey by not isolating one resident (Resident #701) of three sampled residents, and one unsampled resident (Unsampled Resident A), immediately upon presenting signs and symptoms of COVID-19, resulting in the likelihood of the spread of infection with serious complications. Findings include: On 09/09/2020 at 8:20 AM, upon entry in the building, the Director of Nursing (DON) was questioned regarding how many positive COVID-19 cases were in the building. The DON explained that recently they had tested the whole building (staff and residents) and had four positive residents (including Resident #701) and a staff member that had tested positive. The DON further explained that the facility transferred the positive residents to the hospital upon testing positive and that the residents and staff were all asymptomatic (not showing any symptoms). Resident #701 On 09/09/2020 at 10:00 AM, Resident #701 was observed on the COVID-19 unit in bed resting with their eyes closed. There was a Personal Protective Equipment (PPE) station set up outside of the room with a sign posted on the door indicating that the resident was on isolation. The room mate of Resident #701 was heard coughing in the next bed. A record review of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #701 was recently readmitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Resident #701 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating a moderate cognitive impairment. A record review of the Progress Notes for Resident #701 revealed the following: 8/23/2020 01:29 (AM) Health Status Note .resident (#701) sitting up in bed. stated that (Resident #701) was sob (short of breath). schul.(scheduled) up draft (aerosol nebulizer breathing treatment) given .slight congestion noted after updraft to the upper left lung. resident is coughing up secretion's stating that it is clear in color. will monitor. Authored by Licensed Practical Nurse (LPN) B. 8/27/2020 21:30 (9:30 PM) Infection Note .Received faxed Covid 19 test results, Covid detected in 8/26/2020 specimen. Phone call to Dr.(Doctor) .with update on lab result and (Resident #701)'s condition, vital signs stable, no shortness of breath, did have a SOB episode on 8/23/2020 .received order to transfer to (Local Hospital) ER (emergency room) for evaluation and treatment. Dr .phoned ER with orders for work-up. Droplet Plus Precautions in place and will continue until transferred. Report and copies of test results to EMS (Emergency Medical Service) and receiving hospital also notified via phone. There were no other recent chartings of shortness of breath noted in the Progress Notes for Resident #701. A record review of the Orders (Physician) revealed that Resident #701 did not have an order in place for isolation precautions until 08/31/2020. A record review of the test results for Resident #701 revealed that COVID-19 was detected on 08/26/2020. On 09/09/2020 at 12:26 PM, the DON and Infection Control Preventionist (ICP) Nurse C were interviewed regarding Resident #701 having a common symptom of COVID-19 of shortness of breath, and not being placed in isolation on 08/23/2020, and then testing positive three days later. The ICP Nurse C explained that there were no other symptoms during that time. The DON explained that Resident #701 was at baseline and that was tested in the hospital on [DATE] and was negative. The DON further explained that she felt the test results on 08/26/2020 may have been a false positive. On 09/09/2020 at 2:22 PM, Resident #701 was observed awake in bed. Resident #701 was alert and oriented and explained that they were tested for COVID-19 within the facility, had tested positive and then transferred to the hospital. Resident #701 further explained that once they returned to the facility, they were placed in isolation and moved to a new room (current room). On 09/09/2020 at 3:22 PM, the DON and ICP C were queried as to why LPN B did not place Resident #701 in isolation per the Center for Disease Control (CDC) recommendations with an onset of shortness of breath and explained that the resident was in poor health and had chronic [MEDICAL CONDITION] (swelling) and was they felt the resident was at baseline. On 09/09/2020 at 3:34 PM, LPN B was queried via phone, in regard to what prompted her to chart the incident of shortness of breath for Resident #701 on 08/23/2020. LPN B stated, I always chart anything unusual. I charted that (Resident #701) had shortness of breath and that they responded to the nebulizer (in a positive manner), I even went back later on (during the shift) and asked (Resident #701) if they were okay and they said they were. LPN B was asked if Resident #701 was always short of breath and explained that the resident was not always short of breath, but was on occasion. On 09/09/2020 at 4:01 PM, during an interview, the DON explained again that the facility felt that the positive test results that came back were false. The DON was queried if a negative result could be false, and did not comment. A record review for of the care plan for Resident #701 revealed the following COVID-19 care plans: Initiated 04/25/2020- Focus-At risk for COVID-19 r/t (related to) Risk factors Chronic illness, living in close quarters with many people, exposure to health care workers, weak immunity. Goal-Resident will have less risk of transmissible illness AEB (as evidence by) no fewer greater than 100 .new or worsened shortness of breath or cough . Intervention-Monitor for fever equal to or greater than 100 .new or worsened cough/shortness of breath Initiated 09/03/2020- Focus-Resident has active COVID-19 infection. Goal-Will not develop worsening s/sx (signs and symptoms) . Intervention-Maintain (facility) policy transmission precautions . Unsampled Resident A A record review of the July 2020 line listing (a report that the facility documents surveillance of all active infections within the building) revealed that Resident A (no longer in the facility) had documented respiratory symptoms for the month of July that included cough and fever. According to the line listing, Resident A was placed on an antibiotic, had a chest XRay, but was not placed in isolation. A record review of the 07/25/2020 Progress Notes for Unsampled Resident A revealed the following: Resident c/o (complaints of) sore throat. intermittent cough noted to be dry .resident does have low grade fever. PRN (as needed) Tylenol given. Resident educated on increasing fluids. Resident lying in bed resting at this time .will continue to monitor. There were no further notes or orders indicating that Unsampled Resident A was placed in isolation or tested for COVID-19 related to the 07/25/2020 Progress Note. A record review of the care plan for Unsampled Resident A revealed the following: Initiated 06/26/2020- Focus-At risk for COVID-19 r/t Risk factors Chronic illness, living in close quarters with many people, exposure to health care workers, weak immunity. Goal-Resident will have less risk of transmissible illness AEB no fewer greater than 100 .new or worsened shortness of breath or cough . Intervention-Monitor for fever equal to or greater than 100 .new or worsened cough/shortness of breath On 09/09/202 at 4:50 PM, the DON was interviewed in regard to Unsampled Resident A having a fever and cough on 07/25/2020 and not being placed in isolation. The DON explained that the resident was seen by the doctor and placed on cough syrup. During the interview, when explained that Resident #701 (whom presented with shortness of breath three days prior to testing positive) and Unsampled Resident A (had not been tested after showing signs and symptoms on 07/25/2020) had both presented with signs and symptoms of COVID-19, and not placed in isolation, this could have placed other residents and staff members at risk for COVID-19, the DON stated, I see your concern now. A review of the facility policy titled, COVID-19 Surveillance dated 05/11/2020 revealed the following: #8. Residents will be monitored for signs and symptoms of Coronavirus (COVID-19) illness daily: fever, cough, shortness of breath or difficulty breathing .sore throat .Staff shall follow established procedures when COVID-19 is suspected. A review of the facility policy titled, Novel Coronavirus Prevention and Response Revised April 2020 revealed the following: Policy-This facility will respond promptly upon suspicion of illness associated with a novel coronavirus in efforts to identify, treat, and prevent the spread of

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

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) [MEDICAL CONDITION]. #2. Staff shall be alert to signs of COVID-19 and notify the resident's physician if evident: a. Fever b. Cough c. Shortness of breath d. Any additional current screening criteria. #3. Considerations/priorities for testing: a. Use clinical judgment on case-by-case basis to determine if a resident has signs and symptoms compatible with COVID-19. b. Test for other causes of respiratory illness, such as influenza or other respiratory panels. c. Consider known community transmission. d. Prioritize symptomatic residents [AGE] years of age and older and those with underlying conditions that may put them at higher risk for poor outcomes (e.g., diabetes, [MEDICAL CONDITION], receiving immunosuppressive medications, [MEDICAL CONDITION], and [MEDICAL CONDITION]). #5. Interventions to prevent the spread of respiratory germs within the facility: c. Monitor residents for fever or respiratory symptoms. #6. Procedure when COVID-19 is suspected or confirmed: a. Notify physician, Director of Nursing, Infection Preventionist, and family. b. Place resident in a private room (containing a private bathroom) if available, with the door closed. c. Evaluate the need for hospitalization . f. Implement standard, contact, and droplet precautions. Wear gloves, gowns, goggles/face shields, and masks upon entering room and when caring for the resident. i. Avoid aerosol-generating procedures (i.e. suctioning, nebulizer treatments, [MEDICAL CONDITION]) as possible. If required, take the following precautions: i. Perform in private room (AIIR preferred) with door closed, if available. ii. Wear an approved respirator, eye protection, gloves, and a gown. iii. Limit the number of health care personnel present to essential personnel. iv. Clean and disinfect room surfaces promptly after procedure.