| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235013 | A. BUILDING _____ B. WING _____ | 08/11/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| FAIRVIEW NURSING AND REHABILITATION COMMUNITY | 441 E MAIN ST CENTREVILLE, MI 49032 |

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

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| F 0584<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>This citation pertains to MI 881. Based on observation, interview, and record review, the facility failed to ensure a safe and comfortable environment, in one of three residents reviewed for environment concerns (Resident #12) and 3 of 4 resident rooms reviewed room [ROOM NUMBER], 32, & 37, affecting a census of 48 residents, resulting in an increased risk of infections, odors and an unsanitary home surroundings. Findings include: The refrigerator in the pantry was observed on 08/05/20 at 1:30 PM with resident food items. The refrigerator contained a half-gallon of chocolate milk that had been opened, there was no date opened written on the container, the carton was marked with a best buy date of August 3, two days prior to the observation. A half-gallon carton of white milk appeared to be curdled on the bottom of the container and was dated with a marker 7/28 and 8/4; the carton's best by date was 08/01/20. A plastic container of watermelon was observed with best if used by 07/30/20 on the label. An uncovered square metal container was observed not dated and contained what appeared to be dried tuna fish. One drawer of the refrigerator was soiled with spilled liquids and cardboard packaging from what had once been stored in the drawer was stuck to the spilled contents. The door and shelves of the refrigerator were soiled with spilled liquids. An open container of med pass (supplement) was observed not dated. During the observation of the resident refrigerator, on 8/5/20 at approximately 1:35 PM, Registered Nurse H stated she saw the metal container of tuna fish in the refrigerator earlier was going to take care of it, because it was gross. On 08/06/20 at 10:45 AM the wooden slate blinds next to nurses' station were observed soiled with dust and supplement splash. One slat was broken. Licensed Practical Nurse (LPN)/Infection Control Preventionist (ICP) C was interviewed on 08/06/20 at 11:30 AM and stated the dietary department were responsible for cleaning the resident food refrigerator. Resident 12 (R12) On 8/06/20 at 2:00 PM, R12 was observed in her room lying in bed. R12's last Minimum Data Set (MDS) assessment, dated 06/15/20 introduced the Brief Interview for Mental Status (BIMS), a short performance-based cognitive screener for nursing home residents, was a score of 13 (scale 13-15 Cognitively Intact). R12 stated her room wasn't cleaned very well. On 08/11/20 at 10:00 AM the resident food refrigerator freezer was observed with a melted popsicle that dripped down the door and was re-frozen. Hair was attached to the popsicle drips on the inside of the freezer door.<br><br>On 8/6/2020, at 9:30 AM, a strong urine odor was observed while out in the long and short hall of the resident area. In an observation on 8/11/2020, at 8:47 AM, of resident room [ROOM NUMBER] revealed the window blinds had four panels at the bottom of the blinds that were broken, which created an outside view on the room exposing the resident in bed two. Cobwebs were observed on the wall above the head of the bed light from the ceiling down to the light fixture, above the room window, and above the TV. The bathroom return ventilation air vent was not functioning, and observed to have dust build-up inside the vent. Observation of resident room [ROOM NUMBER] on 8/11/2020, at 9:12 AM, revealed a strong odor of urine, the bathroom return ventilation air vent was observed to not be functioning, and had dust build-up inside the vent. Observation of resident room [ROOM NUMBER] on 8/11/2020, at 9:15 AM, revealed the bathroom return ventilation air vent was not functioning, and observed to have dust build-up inside the vent. In an interview on 8/11/2020, at 11:19 AM, Maintenance Staff Member W stated he had been assisting at the facility for about 3 weeks, and would be at the facility two times per week. Maintenance Staff Member W stated he did not know what the facility's policy and procedure for checking the functioning of the return ventilation system was. Maintenance Staff Member W said he contacted the previous Maintenance Staff Member who told him that the last time he checked the ventilation system was on 7/16/2020, but he had no documentation of that. Maintenance Staff Member W said that the roofing company who was replacing the roof of the facility, told him that the debris of rocks and dust that they have cleared off the roof had gone into the ventilation system with rocks and dust about two weeks ago. Maintenance Staff Member W stated the roofing company staff members should have told him about the debris in the ventilation system, but did not. Review of the facility's policy and procedure titled, Air Temperature and Ventilation, not dated, revealed on page #1, under Ventilation, The Maintenance Director is responsible to monitor exhaust systems on a quarterly basis and as needed to ensure adequate ventilation including .odor levels are acceptable, and The Maintenance Director will document findings on the Exhaust System Quarterly Inspection From. |
| F 0585<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>This citation pertains to intake MI 582. Based on interview and record review, the facility failed to ensure grievances were investigated in one of three reviewed for missing items (Resident #10), resulting in unresolved concerns. Findings include: Resident #10 (R10) R10's Minimum Data Set (MDS) assessment, dated 06/07/20, indicated a BIMS score of 03 (scale 00-07 Severe Impairment). The same MDS assessment revealed R10 had the [DIAGNOSES REDACTED]. The same MDS indicated R10's<br>Patient Health Questionnaire (PHQ-9, depression screen tool) score was 8 (scale 5-9 mild depression), and during the 14-day look-back period, he had a poor appetite or overeating, for 7 to 11 days, half or more of the days during the look-back period. 08/05/20 at 9:40 AM Certified Nurse Assistant (CNA) R stated during an interview that she was asked about R10's snacks, she had heard they were missing, but had not seen any snacks. CNA R stated R10's snacks were brought in after she had left for the day. Nursing Home Administrator (NHA) A was interviewed on 08/06/20 at 10:55 AM and stated she did not have a Missing Item Report for R10's snacks and wasn't aware of any missing snacks. During the same interview, NHA A called the social worker at his extension and he stated he was not aware of R10 missing snacks. Licensed Practical Nurse (LPN)/Infection Control Preventionist (ICP) C was interviewed on 08/06/20 at 11:30 AM and stated she heard about R10's missing snacks, but I thought they were recovered. ICP C stated she thought Director of Nursing (DON) B handled R10's concern regarding missing snacks. DON B was not available for an interview. CNA a was interviewed on 08/06/20 at 12:07 PM and stated R10's resident representative brought snacks to the door on 07/26/20, and the nurse put some of the snacks in the refrigerator and some snacks in room. CNA a didn't hear R10's snacks were missing. On 8/6/20 at 2:15 PM LPN I stated she was the nurse that received R10's snacks from R10's resident representative on or about 07/26/20. LPN I stated during the same interview, she didn't know what was in the box of snacks or what happened to the snacks after she gave them to the aide to take care of. LPN I stated she did not write R10's name on the snack items. LPN I stated she didn't remember the aide she gave the snacks too. LPN I stated she heard R10's resident representative was upset regarding R10 not receiving his snacks. LPN I stated she didn't report the snacks missing because she didn't know they were missing. Social Worker G was interviewed on 08/06/20 at 3:05 PM and stated he had contacted R10's resident representative and had noted a list 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 0585<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>missing snacks on a Grievances/Concerns form. In review of the facility's Grievances/Concerns policy dated 10/2017, the facility would support the resident's right to voice grievances and would take prompt actions to resolve grievances/concerns and keep the resident apprised of progress towards resolution. The same policy indicated the Social Services Director and Administrator would lead an investigation. The same policy indicated if the grievance/concern was a missing item, a missing item report would be completed. |
| F 0770<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Provide timely, quality laboratory services/tests to meet the needs of residents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>This citation pertains to MI 734. Based on observation, interview and record review, the facility failed to ensure laboratory specimens obtained from 48 residents and 49 staff were sent to the laboratory (lab) and preserved at the recommended temperature, resulting in non-viable specimens. Findings include: A cardboard box with specimens collected from staff for the purpose of testing COVID-19 RT-PCR were observed inside the box with a insulated lining and no ice packs; the top of the box was open, and sitting on a counter behind the nurses station on 08/06/20 at 2:05 PM. Licensed Practical Nurse (LPN)/Infection Control Preventionist (ICP) C stated Director of Nursing (DON) B had conveyed to her that COVID-19 specimens did not need to be refrigerated or placed on ice packs. In review of a lab spreadsheet titled AZOA75 and Staff, 34 specimens were collected on 08/04/20, 5 specimens were collected on 08/05/20, 8 specimens were collected on 08/06/20, and 4 specimens were collected on 08/07/20. In review of lab spreadsheet titled AZOA75 and Resident, 48 resident specimens were collected on 08/04/20 and shipped on 08/07/20. On 08/11/20 at 10:45 AM, Regional Clinical Nurse (RCN) L stated 48 out of 51 staff COVID-19 samples and 48 out of 48 resident COVID-19 samples were shipped to Lab b on 08/07/20, expected to arrive at the lab via overnight delivery by 08/08/20. On 08/11/20 at 10:45 AM, RCN L stated lab b sent an electronic mail (email) that did not instruct to refrigerate the samples. During week of survey, Lab b sent complete instructions, including to refrigerate COVID-19 test samples. RCN L stated in the same interview, samples collected from staff on 08/04/20 through 08/07/20, for COVID-19 testing were not refrigerated and they were picked up for shipment to the lab on 08/07/20. RCN L stated Resident samples for COVID-19 testing were collected on 08/04/20 and shipped on 08/07/20 without ice packs. 08/11/20 Lab Manager M stated if COVID-19 samples would be viable at room temperature for 24 hours after collection, and for 3 days if refrigerated. Staff Samples collected on 8/4/20 through 8/7/20 were shipped on 08/07/20 and received at the lab on 08/08/20 at 9:11 AM. Lab Manager M stated samples should have been flagged and she would investigate. The Laboratory Services Agreement indicated Lab b had a contract with the facility that began as of 07/23/20. According to the Lab b's website, As of March 13, the CDC (Centers for Disease and Control) recommends collecting only the upper respiratory nasopharyngeal (NP) swab and immediately place in 2-3 mL (milliliters) of [MEDICAL CONDITION] transport media. Refrigerate specimen at 2-8 (degrees) Celsius. According to Lab b's Nasopharyngeal Swab Sample Collection Instructions, if specimens will be examined within 48 hours after collection, keep specimen at 4 degrees Celsius and ship on wet ice or refrigerant gel-packs, otherwise store frozen. Lab b's COVID-19 & Respiratory Pathogens Panel Specimen Requirements, indicated COVID-19 test sample stability at room temperature was 1 day and if refrigerated 3 days. The CDC's website indicated to store specimens at 2-8 degrees Celsius for up to 72 hours after collection. If a delay occurs in extraction, store specimens at -70 degrees Celsius or lower. The Food and Drug Administration COVID-19 Policy retrieved at https://documents.cap.org/documents/FDA-IIE-COVID19-Guidance.pdf indicated All clinical tests should be validated prior to use. In the context of a public health emergency, it is critically important that tests are validated because false results can negatively impact not only the individual patient but also can have broad public health impact. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>This citation pertains to intake MI 734 and MI 582. Based on observation, interview, and record review the facility failed to properly maintain infection control practices, for COVID-19 for six out of nine residents (Resident #'s 7, 20, 21, 22, 23, 24), cleaning of resident equipment, maintenance of resident food in the refrigerator, use of personal protective equipment and staff education, resulting in the potential for the spread of Covid 19. Findings Included: Observation on 8/5/2020, at 9:16 AM, of the Long Hall revealed a plastic wall barrier that separated rooms 38 & 39, which were identified to be the facility's designated isolation rooms for Covid 19, from the non-isolation resident rooms. Resident #7 (R7): Per the facility face sheet R7 was admitted to the facility on [DATE]. Record review of a Covid 19 laboratory test result, dated 7/27/2020, revealed R7 tested positive for Covid 19. Review of R7's rooms census report revealed R7 resided in room [ROOM NUMBER]-2, and was moved to the Covid 19 isolation area room [ROOM NUMBER]-2 on 7/28/2020, one day after R7's positive Covid 19 test result was received by the facility. The report revealed R7 was moved back to room [ROOM NUMBER]-2 on 8/2/2020, five days after being moved to the Covid 19 unit. Record review of a progress note, dated 7/27/2020, revealed R7 was moved into COVID precautions, and another note on the same day revealed R7 was in Covid isolation. Resident #22 (R22): Per the facility face sheet R22 was admitted to the facility on [DATE] to room [ROOM NUMBER]-1, and was the roommate of R7. Review of R22's room census report revealed R22 had not had a room change at the time R7 tested positive for Covid 19. Record review of R22's progress notes revealed no notation that indicated R22 had been placed in any increased observation or isolation precautions after R7 had tested positive for Covid 19 on 7/27/2020. Record review of R22's care plans revealed a care plan, dated 3/18/2020, that R22 was at risk for, Psychosocial Well-Being related to federal and state directed Covid 19 restrictions, and being at risk for contracting Covid 19. The care plan did not have any interventions that indicated R22 was placed in any type of increased observation or isolation precautions related to R7's positive Covid 19 test result, and possible exposure to Covid 19. No other care plan related to Covid 19 was found in R22's Electronic Medical Record (EMR) or paper medical records. Resident #20 (R20): Per the facility face sheet R20 was admitted to the facility on [DATE], and re-admitted on [DATE]. Record review of a Covid 19 laboratory test result, dated 7/21/2020, revealed R20 tested positive for Covid 19. Review of R20's rooms census report revealed R20 resided in room [ROOM NUMBER]-1, and was moved to the Covid 19 isolation area room [ROOM NUMBER]-2 on 7/22/2020, one day after R20's positive Covid 19 test result was received by the facility. The census report revealed R20 was moved back to room [ROOM NUMBER]-1 on 7/30/202, eight days after being moved to the Covid 19 unit. Record review of a progress note, dated 7/22/2020, revealed R20 had a room change and was moved into Covid 19 isolation precautions. Resident #24 (R24): Per the facility face sheet R24 was re-admitted to the facility on [DATE] to room [ROOM NUMBER]-2, and was the roommate of R20. Record review of R24's room census report revealed R24 had not had a room change at the time R20 tested positive for Covid 19. Record review of R24's progress notes revealed no notation that indicated R24 had been placed in any increased observation or isolation precautions after R20 had tested positive for Covid 19 on 7/22/2020. Record review of R24's care plans revealed a care plan, dated 3/17/2020, that R24 was at risk for, Psychosocial Well-Being related to federal and stated directed Covid 19 restrictions, and being at risk for contracting Covid 19. The care plan did not have any interventions that indicated R24 was placed in any type of increased observation or isolation precautions related to R20's positive Covid 19 test result, and possible exposure to Covid 19. No other care plan related to Covid 19 was found in R24's Electronic Medical Record (EMR) or paper medical records. Resident #21 (R21): Per the facility face sheet R21 was admitted to the facility on [DATE]. Record review of a Covid 19 laboratory test result, dated 7/21/2020, revealed R21 tested positive for Covid 19. Review of R21's room census report revealed R21 resided in room [ROOM NUMBER]-2, and was moved to the Covid 19 isolation area room [ROOM NUMBER]-3 on 7/22/2020, one day after R21's positive Covid 19 test result was received by the facility. The census report revealed R21 was moved back to room [ROOM NUMBER]-2 on 7/30/2020, eight days after being moved to the Covid 19 unit. Record review of a progress note, dated 7/22/2020, revealed R21 was moved to Covid 19 precautions, and another note, dated 7/25/2020, revealed R21 was upset that he was in the Covid Unit. Resident #23 (R23): Per the facility face sheet R23 was re-admitted to the facility on [DATE]. Record review of R23's room census report revealed R23, was moved to room [ROOM NUMBER]-1 on 6/22/2020, but had not had a room change at the time R21 tested positive for Covid 19. Record review of R23's progress notes revealed no notation that indicated R24 had been placed in any increased observation or isolation precautions after R21 had tested positive for Covid 19 on 7/21/2020. Record review of R23's care plans revealed a care plan, dated 3/17/2020, that R23 was at risk for, Psychosocial Well-Being related to federal and state directed Covid 19 restrictions, and being at risk for contracting Covid 19. The care plan did not have any interventions that indicated R24 was placed in any type of increased observation or isolation precautions related to R21's positive Covid 19 test result, and possible exposure to Covid 19. No other care plan related to Covid 19 was found in R23's Electronic Medical Record (EMR) or paper medical records. In an interview on 8/6/ :0, at 12:30 PM, Medical Director (MD) D stated the facility is following the Centers for Disease Control and Prevention (CDC) symptom based criteria, and said that was the most recent guidance from the CDC. MD D said the guidance was 10 days with the signs and symptoms of Covid 19 and the resident could |

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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | (continued... from page 2)<br>then come out of the Covid 19 isolation unit. MD D said if a resident tested positive for Covid 19 then the resident was to be moved to the Covid 19 unit, and the resident's roommate would stay in the room the positive resident resided in with them, and was not put into and increased isolation, or other precautions. According the the CDC, at https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized -patients.html, Symptom-Based Strategy for Discontinuing Transmission-Based Precautions. For patients who are not severely immunocompromised and who were asymptomatic throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days have passed since the date of their first positive [MEDICAL CONDITION] diagnostic test. Record review of the facility's policy and procedure titled, 2019 Novel Coronavirus Covid 19, dated 5/2020, revealed on page #3, Dedicated medical equipment should be used when caring for patients with known or suspected COVID 19. All non-dedicated, non-disposable medical equipment should be cleaned and disinfected according to manufacture's policy between each resident. The policy did not reveal the CDC guidelines for the symptom based strategy for discontinuing transmission based precautions 10 days without symptoms after testing positive of their first [MEDICAL CONDITION] positive test. In an interview on 8/6/2020, 2:08 PM, Administrator A stated that the Covid 19 policy and procedure was last updated May of 2020. In an interview on 8/5/2020, at 9:38 AM, Certified Nurse Aid (CNA) R stated that she had been working at the facility for two years. CNA R said R22, 23 & 24 were not put into any type of isolation when their roommate (R7, 20 & 21) tested positive for Covid 19. CNA R further stated that if cleaner/disinfectant wipes were available then the CNAs would clean the vital sign (VS) machine that was used to take resident vital signs (blood pressure, temperature, oxygen saturation). CNA R stated the wipes were not always available, but if they were available they were locked in the nurses' medication cart, and stated the CNAs would have to ask the nurse to unlock the cart and get them for their use. CNA R said she had not been directed to use any other cleaning/disinfectant product. CNA R also stated that she could ask the housekeeping staff for bleach, but said that was usually locked up also. CNA R said the housekeeping staff was gone everyday about 3:00 or 4:00 PM, and stated there was no 2nd shift housekeeping. CNA R said the CNAs did not clean the mechanical lifts in between resident use, and said the VS machine was never cleaned between resident use. CNA R said the CNAs used the same VS machine in the Covid 19 unit that they used outside of the Covid 19 unit, and stated the blood pressure cuff on the VS machine was the only one available to use. In an interview on 8/5/2020, at 9:16 AM, CNA Q stated that she had been employed at the facility for one month. CNA Q said she had not received any education on the cleaning/disinfectant products contact times, and said she did not know what that meant. CNA Q stated that cleaning/disinfectant wipes were used to clean resident equipment. CNA Q said that she believed the cleaning wipes were stored in the VS machine basket, and she did not know where to get more cleaning products if needed. CNA Q said she did not know what the requirement for cleaning the VS machine and mechanical lifts were, and said the mechanical lifts were just pushed into the hall after each resident use and not cleaned. Observation of the VS machine, with CNA Q immediately following the interview, revealed the VS machine was stored at the nurses' station and no wipes were observed in the basket, or any other cleaner/disinfectant product. Continued observation with CNA Q revealed there was no cleaner/disinfectant product in the clean storage supply closet, soiled utility room,or main supply closet in the hall of the resident area. In an interview on 8/5/2020, 10:35 AM, Licensed Practical Nurse (LPN) X, CNA Y stated the cleaning/disinfectant wipes were locked up in the nurses' medication cart, and stated there were none available at the time, and said, we ran out yesterday. CNA Y stated that water and a wash clothe was what she used to clean resident equipment such as the VS machine, and mechanical lifts. On 8/5/2020, at 10:28 AM, the VS machine was observed in same spot at the nursing station with no cleaning wipes in the basket. In an interview on 8/5/2020, at 3:00 PM, Housekeeper (Hskp) S there were no cleaning/disinfectant wipes available, and said they were never available. Hskp S said resident equipment/items were cleaned with a bleach solution. Hskp S said she had not ever been asked by a CNA or nurse for cleaning/disinfectant wipes or other cleaning supplies, and stated that there were only two housekeeping staff members at the time, herself and one other whom both worked 7:00 AM to 3:00 PM. Observation of VS machine at the nurses' station on 8/5/2020, at 3:14 PM, revealed no cleaning/disinfectant wipes in the basket on the VS machine. 8/5/2020, at 3:20 PM, Registered Nurse (RN) H stated that no cleaning/disinfectant wipes had been available for a couple of days. RN H said the CNAs had to ask us for wipes, because they were locked up in the med carts. RN H also stated that R22, 23, and 24 were not put into any increased observation/isolation when their roommates (R7, 21, and 20) tested positive for Covid 19, and said no PPE isolation carts were placed by their room doors. In an interview on 8/5/2020, 3:49 PM, Administrator A said the CNAs and nurses used cleaner/disinfectant wipes to clean the VS machine, and resident equipment. Observation on 8/6/2020, at 9:30 AM, of the VS machine at the nurses' station revealed no cleaning/disinfectant wipes observed in the basket on VS machine. In an interview on 8/6/2020, at 9:39 AM, CNA T stated that there were no cleaning/disinfectant wipes available, and said the CNAs were not allowed access to the wipes. CNA T said VS were being done on all residents every eight hours, and when there were residents who were positive for Covid 19 vital signs were then taken every four hours. CNA T said she had not seen the VS machine cleaned but only one time on 8/5/2020, and said it had not been cleaned yet today (8/6/2020). CNA T then stated the VS machine had not been cleaned in the past three days. CNA T said the VS machine was the same VS machine that was used in the Covid 19 unit that was used outside of the Covid 19 unit. CNA T said she had not observed any type of audits to assure staff were cleaning resident equipment, and maintaining infection control practices/procedures. CNA T stated that R22, 23, and 24 were not put into any increased observation/isolation when their roommates (R7, 21, and 20) tested positive for Covid 19. CNA T further stated that the CNAs had two mechanical lifts available for use, and 10-11 residents who required the use of the mechanical lifts, and stated the mechanical lifts were to be cleaned after every resident use. In an observation on 8/6/2020, 10:16 AM, with CNA U and CNA V of a mechanical lift transfer with R29 from his bed to his wheelchair, revealed CNA V did not wash her hands upon entry to R29's room, or prior to proceeding to his bedside. Upon completion of the mechanical lift transfer CNA V pushed the mechanical lift into the hallway outside of R29's room then left it there without cleaning it. In an observation on 8/6/2020, at 10:25 AM, CNA U entered room [ROOM NUMBER] with the VS machine, obtained the temperature and oxygen level of bed one, then proceeded to obtain vital signs of the resident in bed two, then exited the room. CNA U did not clean the VS machine in between use of the two residents in room [ROOM NUMBER]. CNA U did not wash her hands prior to entering room [ROOM NUMBER], nor in between taking the vital signs of each resident in room [ROOM NUMBER]. CNA U was then observed to go across the hall to room [ROOM NUMBER] with the VS machine, and enter the room. CNA U did not clean the VS machine prior to entering room [ROOM NUMBER]. Upon completion of obtaining vitals signs in room [ROOM NUMBER] CNA U was observed to take the VS machine back to the nursing station and left it there. CNA U did not clean the VS machine upon completion of obtaining VS in room [ROOM NUMBER], nor at the point of leaving the VS machine at the nurses' station. CNA U was interviewed immediately following the observation on 8/6/2020, at 10:30 AM. CNA U stated there was one bottle of bleach spray, only if it was available, and said there was supposed to be another bottle available, but there was not. CNA U also stated cleaner/disinfectant wipes were not available either, and when they were the nurses' would have them on their locked med carts were the CNAs did not have direct access to them. CNA U said the mechanical lifts were not cleaned in between each resident use, nor was the VS machine after each resident use. CNA U said that was not required, but only at the end of each shift. CNA U said she had never seen any management staff member or other staff member perform any audits out on the floor to ensure staff were maintaining infection control practices. In an interview on 8/6/2020, at 11:28 AM, LPN C, who was the Infection Control Preventionist, stated R22, 23, & 24, the roommate of R7, 20, & 21, were not placed into any increased isolation or droplet precautions when R7, 20 & 21 tested positive for Covid 19. LPN C said the CNAs were to clean the VS machines and mechanical lifts after each resident use. LPN C said the CNAs have the cleaning/disinfectant wipes available on the VS machine. LPN C stated that she did not do any investigation of the R7, 20, and 21's positive Covid test results for infection control surveillance, such as investigating any infection control practices/processes that could have contributed to the outbreak. In an observation and interview on 8/6/2020, at 2:58 PM, CNA P stated that she had been employed at the facility for one week. CNA P was observed to enter room [ROOM NUMBER] to take the vital signs of the resident in bed two with the oxygen saturation device and thermometer. CNAP did not wash her hands upon entrance in room [ROOM NUMBER], then proceeded to take the vital signs of the resident in bed two with the thermometer and oxygen saturation device, exited room [ROOM NUMBER] without washing her hands before exiting the room. CNA P was then observed to enter room [ROOM NUMBER], did not wash her hands upon entering the room, or prior putting the oxygen saturation device onto the resident's finger who resided in bed one. CNA P then obtained the resident's temperature, got a blanket for resident, and then exited the room. CNA P did not wash her hands prior to exiting room [ROOM NUMBER]. CNA P did not clean/disinfect the oxygen saturation device or thermometer in between resident use, and stated that she was never told she needed to clean the resident equipment, or in between resident use of the equipment. CNA P further stated there were no cleaning/disinfectant wipes available, so if something needed to be cleaned |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235013 | A. BUILDING _____ B. WING _____ | 08/11/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| FAIRVIEW NURSING AND REHABILITATION COMMUNITY | 441 E MAIN ST CENTREVILLE, MI 49032 |

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<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | (continued... from page 3)<br>the CNAs would use a resident peri care dry wipes, by wetting it and cleaning resident equipment. In an interview on 8/7/2020, at 1:22 PM, Administrator A stated the staff were observed for infection control practices, and the documented audits were our validation of staff performance of proper infection control practices. Administrator A said the roommates (R22, 23 & 24) of residents 7, 20, & 21 were not put into increased isolation precautions. Administrator A further stated, regarding the day's delay of moving R7, 20, & 21 to the Covid 19 unit, that the time of the notation in the resident's progress notes and room census was not the true time that the resident was moved. In an interview on 8/7/2020, at 2:00 PM, Business Office Manager (BOM) F stated the she was the staff member who documented in the room census report the resident's room change and date of. BOM F said she documented the exact date the residents moved to their new rooms. Record review of the facility audits titled, Facility Covid 19 Preparedness, revealed the only audits received were dated 7/8, 7/15, 7/22, 7/29, and 8/5/2020. No other audits were received for the months of April, May, or June 2020. The audits did not reveal an audit related to cleaning of resident equipment in between resident use. In an interview and observation on 8/6/2020, at 2:45 PM, Hskp O stated the she would tell the CNAs how to mix the cleaner/disinfectant with water. Hskp O said the CNAs were to fill the empty spray bottle about one quarter full with the bleach then the rest of the spray bottle with water. Observation of the spray bottle Hskp O referred to in the shower room, revealed a plastic spray bottle with a liquid solution in it. The bottle did not have a label on it that identified the solution, nor was the bottle of solution dated. Hskp O said she was not sure who made up the bottle of solution, and was observed to dump the solution out of the spray bottle down the drain at 2:40 PM, and place the empty spray bottle back onto the shelf in the shower room. Hskp O said she would make up the solution into the spray bottle every morning around 7:00 AM, and then toss it out before she left everyday at 3:00 PM. Hskp O said the CNAs could make more if they need to, but stated the solution was only used to clean resident shower chairs and beds. Hskp O further stated that the CNAs usually used the cleaning/disinfectant wipes for cleaning the VS machine, wheelchairs, and mechanical lifts. At 2:55 PM Hskp O left the empty spray bottle in the shower room. In an observation on 8/6/2020, at 2:45 PM, the VS machine was observed at the nurses' station, and had no cleaning/disinfectant wipes in the basket on machine. In an interview on 8/6/2020, at 1:21 PM, RN Z, who stated that she did not work at the facility anymore, said her last day of work was on 7/9/2020. RN Z said she was told by BOM F that she tested positive on 7/9/2020 at 9:55 AM, but stated she was not made aware until 2:30 PM, at the end of her shift that she was positive. RN Z stated that there were no cleaner/disinfectant wipes available for the CNAs to use, and only one container was available for the nurses to share. RN Z said she had never observed the resident VS machine, nor a mechanical lift be cleaned/disinfected after each resident use. Record review of [DIAGNOSES REDACTED]-CoV-2 tests result for RN Z's test result was received at the facility on 7/9/ at 9:50 AM, per a facsimile time stamp. Review of RN Z time punch card revealed that on 7/9/2020 RN Z punched into work at 5:53 AM, and punched out at 2:33 PM, working a total of 7.98 hours on 7/9/2020. In an interview on 8/6/2020, at 3:18 PM, BOM F stated that she was the staff member who would get the faxed Covid 19 test results off the fax machine. BOM F stated that her office was right across from the fax machine room, and when she would hear the beep of the fax machine she check it to get the Covid 19 laboratory results.<br><br>During an interview with Licensed Practical Nurse (LPN) X on 08/05/20 at 9:15 AM, she stated staff wear a respirator (N95) mask during the 8 hour shift and also reuse the N95 masks. LPN X stated they had bags with their name on in medication room, to store the N95 masks at the end of the shift and they wear them until the elastic breaks, approximately 2 weeks. On 08/05/20 at 1:40 PM, a bottle of eye wash was observed over the sink at the nurses' station, with an expiration date stamp of 01/2020. On 08/05/20 at 1:45 PM, LPN X stated they had been out of wipes to clean the glucometers for a couple of days, and that she had used alcohol wipes to clean the glucometer today. Both nurses' medication carts were observed and did not have wipes in the drawers. Licensed Practical Nurse (LPN)/Infection Control Preventionist (ICP) C was interviewed on 08/06/20 at 11:30 AM and stated she was not able to complete any IC duties the past month because she had been pulled to the unit to work as a floor nurse due to lack of staff. ICP C stated she was supposed to work on IC one day per week. ICP C stated she had not been part of the facility's IC meetings. ICP C stated N95 masks were changed when visibly soiled; and if not soiled, they spray the N95 mask with alcohol and store in a paper bag for up to 2 weeks. 08/05/20 at 2:30 PM Nursing Home Administrator (NHA) was interviewed and stated wipes to clean glucometers were available and were in the Director of Nursing's office. NHA A obtained the wipes and distributed the wipes to the nurses. On 08/07/20 at 11:00 AM, ICP C stated the glucometers were cleaned with bleach wipes and did not know what contact time was or how long the device needed to stay wet for disinfecting. In review of the glucometer user instruction manual, it was important to follow the disinfectant product label instructions to ensure proper drying time. According to the website for the wipes with the purple top at https://pdihc.com/products/environment-of-care/super-sani-cloth-germicidal-disposable-wipe/, overall contact time was 2 minutes. In review of the Centers for Disease Control website at https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html; When [MEDICATION NAME] extended use of N95 respirators, the maximum recommended extended use period is 8-12 hours. Respirators should not be worn for multiple work shifts and should not be reused after extended use. |