STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235209	A. BUILDING _____ B. WING _____	04/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF LEELANAU	124 W 4TH STREET SUTTONS BAY, MI 49682

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 that infection control parameters were maintained during a focused COVID-19 survey regarding the screening process (required during COVID-19 emergency to prevent those with symptoms from entering the facility), hand hygiene during pericare for one Resident (#1), isolation for residents with COVID-19 related symptoms for one Resident (#2), and the cleaning of reusable patient care equipment. This deficient practice resulted in the potential for the spread of COVID-19 related illness to the entire facility population. Findings include: On 4/21/20 at 10:06 a.m., Hospital Lab Licensed Practical Nurse (LPN) C was observed waiting in the double door area of the front lobby. Registered Nurse (RN) L went out to the area and helped LPN C screen herself. RN L had LPN C sign in on the Staff log. On 4/21/20 at 10:08 a.m., RN L was asked whether LPN C worked at the facility. RN L stated, No she's from the (local hospital) lab. When asked why she had been directed to sign on the Staff log, RN L stated, I think that's what they normally have her do. I don't know. I'm new. When asked if LPN C had filled out the visitor log, RN L stated, No. LPN C did not indicate on the log which residents she would see to obtain lab specimens. (The local hospital was known to treat active COVID cases.) On 4/21/20 at approximately 10:30 a.m., RN L was observed to enter the double door area of the front lobby where Physician B was signing herself in to the building. Physician B took the [MEDICATION NAME], infrared thermometer and swiped it against her forehead making contact with her skin. RN L did not ask Physician B to retake her temperature, and Physician B continued into the building. On 4/21/20 at 10:46 a.m., RN L was observed entering the double door area of the front lobby where Nurse Practitioner (NP) D was waiting to be screened in. RN L was observed filling out the visitor form which asked the screening questions and included education on the bottom regarding what to do if the said visitor were to start exhibiting symptoms for NP D. On 4/21/20 at 10:48 a.m., RN L was asked about Physician B taking her own temperature and doing so incorrectly. RN L stated, She wouldn't let me do. When asked why she didn't ask Physician B to retake the temperature, RN L reported she didn't realize it was different type of thermometer, and that they used to have a sensor one that worked by swipe on the forehead. When asked if they had signed the log, RN L showed the log which did not indicate which residents Physician B or NP D were there to see. On 4/21/20 at 11:00 a.m., a review of the Visitor log revealed that LPN C, Physician B, and NP D did not leave a phone number for contact tracing, nor did they indicate which residents they were there to see. On 4/21/20 at 11:06 a.m., the screening process and logs were reviewed with the Administrator, which revealed there were no times of entry and exit logged for visitors. The Administrator reported he would fix the log forms. When asked for a policy that went through the screening process, the Administrator reported there wasn't a specific policy or procedure for that. When asked how visitors were educated about handwashing and monitoring for symptoms, the Administrator reported that each visitor was supposed to fill out the visitor form themselves so they could read the education at the bottom. A review of the manufacturers guidelines for the [MEDICATION NAME] infrared thermometer revealed, .3 Press the Scan Button, point towards the forehead form a distance of 1.2 to 2 inches away and press the Scan Button again to take the temperature. Tips: Do not move the thermometer before the testing is done. On 4/21/20 at 8:50 AM, the screening process was observed performed on this Surveyor and Surveyor team member. Staff G initially asked these Surveyors to self screen. When asked to perform screening process as with any other visitor, Staff G attempted to screen these Surveyors. Staff G failed to ask this Surveyor any screening questions following temperature check. The Administrator asked this Surveyor to enter the building. Resident #2 On 4/21/20 at 9:00 AM, the Administrator asked screening questions and filled out the questionnaire after this Surveyor had already been granted access to the facility and had been directed to an office area within the facility. On 4/21/20 at 9:30 AM, an isolation cart for Resident #2 was observed in the hallway. At that time, RN H stated Resident #2 was under isolation under suspicion of strep throat. RN H stated, (Resident #2) had a fever of 100.5 a couple of days ago, and complained of a sore throat. A review of the Electronic Medical Record (EMR) face sheet for Resident #2 revealed admission to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the EMR progress note for Resident #2 dated 4/13/20 at 14:33 (2:33 PM) revealed the following: Noted dry cough, T(temperature)=100.1, shortness of breath, COVID-19 testing negative from the hospital prior to discharge, ED (Emergency Department) diagnosed with [REDACTED].#2 dated 4/19/20 at 15:00 (3:00 PM), revealed Resident #2 . had a temp of 100.5 . on 4/19/20 and . also c/o (complained of) a sore throat . A review of the EMR progress note for Resident #2 dated 4/20/20 at 7:00 AM, Resident #2 . still c/o sore throat. On 4/21/20 at 10:50 AM, Resident #2 was observed being treated in the shared therapy gym for the facility by Physical Therapist (PT) I. On 4/21/20 at 10 :50 AM, an observation and interview with RN H and PT I revealed the following: RN H and PT I were observed talking in the therapy gym. PT I interrupted the treatment of [REDACTED].#2 back to his wheelchair. PT I then transported Resident #2 back to his room. PT I then stated to Resident #2 the therapy session would be completed in the room. When asked if Resident #2 should have been treated in the therapy gym, RN H stated No. We didn't have morning meeting so it (isolation precautions) wasn't effectively communicated. On 4/21/20 at 11:20 AM, an interview with PT I revealed the following: When asked if PT I was aware Resident #2 was on isolation precautions related to COVID-19 pathway, and treatment should not be performed in a common area, PT I stated, I wasn't aware of residents not being able to be in the therapy gym if they were running a fever. I have only been here for three days. When asked if they were educated on COVID-19 policies for the facility, PT I stated, No. On 4/21/20 at 11:22 AM, an interview with Certified Occupational Therapy Assistant (COTA) F revealed the following: When asked if COTA F had any education regarding COVID-19, and residents not being in a common area such as a therapy gym when under isolation, COTA F stated, I was not aware until today. When asked if any specific education was provided regarding residents who are under quarantine, COTA F stated, No. A review of the COVID-19 pathway (undated), provided by the facility, revealed the following: Does resident have temperature exceeding 100.4, cough, or shortness of breath? . Yes . begin isolation precautions . resident is not to leave room until afebrile (absence of fever)/asymptomatic (absence of symptoms) for 72 hours. A progress note dated 4/21/20 at 9:46 AM revealed droplet precautions were removed for Resident #2, however Resident #2 had not been symptom-free for 72 hours, as directed in the facility COVID-19 pathway. Resident #1 On 4/21/20 at 1:45 AM, Certified Nurse Aide (CNA) J, and CNA K were observed performing a lift transfer and incontinence care for Resident #1. The recliner was noted to have bowel movement (BM) spot remaining on the sitting surface, which appeared to have leaked out of the brief. Resident #1 was transferred to the bed using a sit to stand lift on top of a bath blanket. Both CNA J and CNA K were observed performing perineal hygiene following an episode of bowel incontinence. CNA J and CNA K proceeded to place a new brief and assist Resident #1 in rolling back and forth to adjust the brief without changing the gloves or performing hand hygiene following the bowel incontinence care. The soiled gloves of CNA J and CNA K touched the upper body clothing and the new brief. CNA J proceeded to perform hand hygiene for 5 seconds and then replaced gloves to assist Resident #1 with putting on new pants. CNA K had still not changed gloves or performed hand hygiene. New pants were placed on Resident #1 and then hand washing was then performed by both CNA J for 12 seconds, and CNA K for 11 seconds. Immediately following the incontinence care CNA J performed cleaning of the mechanical lift. CNA J left the sling used for Resident #1 on the

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 -** Many	(continued... from page 1) lift throughout the cleaning and did not use anything to sanitize the reusable equipment. When asked if the sling was supposed to be sanitized in some way between residents, CNA J stated she did not know and proceeded to ask RN L if there was any special process used to sanitize the lift sling. RN L indicated uncertainty in whether or not there was a process to sanitize reusable equipment link a mechanical lift sling. CNA J was then brought back into Resident #1's room and was asked if there was anything she would do with the recliner chair. CNA J did not have a response until after the BM soiled spot was pointed out. On 4/21/20 at 2:10 PM, the Director of Nursing (DON) was asked what should be done following removal of a brief and before placing a new brief and clothing on a resident. The DON motioned with hands the removal of gloves, and washing of hands. A review of the EMR face sheet for Resident #1 revealed admission to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the facility policy Standard Precautions with a reviewed date of 2/2018 revealed the following: Standard precautions will be used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard Precautions presume that all blood, body fluids, secretions, and excretions . may contain transmissible infectious agents . 1. Hand Hygiene . b. Hands shall be washed with soap and water whenever visibly soiled with dirt, blood, or body fluids, or after direct or indirect contact with such . 2. Gloves . e. Change gloves, as necessary, during the care of a resident to prevent cross-contamination from one body site to another (when moving from a 'dirty' site to a 'clean' one . g. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces . and wash hands immediately to avoid transfer of microorganisms . 5. Resident-Care Equipment a. Handle used resident-care equipment soiled with blood, body fluids, secretions, excretions in a manner that prevents . transfer of other microorganisms to other residents and environments. b. Ensure that reusable equipment is not used for the care of another resident until it has been appropriately cleaned and reprocessed .