STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235547	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEPOINTE SENIOR CARE AND REHAB CENTER, L L C	37700 HARPER AVENUE CLINTON TOWNSHIP, MI 48036

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 follow accepted standards of Infection Control practice including, but not limited to, 1) the failure to ensure that five residents (#300, #302, #303, #304, and #310) out of eleven residents reviewed were tested and isolated for COVID-19 timely after developing signs and symptoms of respiratory illness 2) the failure to ensure that appropriate Personal Protective Equipment (PPE) was made available for staff to wear when caring for residents during the onset of a COVID-19 outbreak at the facility and 3) communicate collaboratively with the County Heath Department upon notification of first positive COVID-19 test results resulting in the spread of COVID-19 among residents and staff of the facility, including 71 residents of the facility residents had test positive for COVID-19, resulting 21 COVID-19 positive related deaths (including Resident's #302, #303, and #304) and a total 30 staff members had tested positive for COVID-19 and an additional 33 staff member were out sick with COVID-19 related symptoms. Findings include: During a tour of the facility on [DATE] at 1:30 p.m. in the presence of the Director of Nursing (DON)/Infection Control (IC) Nurse she stated their first case of COVID-19 in their building was end of [DATE] or early [DATE]. She stated that the staff wear full personal protective equipment on the monitoring unit. During tour of the A wing strong odor of urine was noted and used gloves were observed on the handrail outside of a resident room. According to facility document titled, COVID Summary, The facility had 71 COVID positive residents. The facility census at the time of survey was 86. Six of the 71 COVID positive residents expired at the facility and fifteen expired at the hospital. The facility had 30 COVID positive employees out of a total of 118 employees and reported that an additional 33 employees were off work since March with COVID-like symptoms that did not test for COVID-19. According to facility document titled, (Facility Name) Infection Control Monitoring Map; Resident COVID-19 2020 Mapping (Dates), the facility had no residents positive, presumed positive or being monitoring for COVID-19 until the week of ,[DATE]-,[DATE] when a resident was presumed positive for COVID-19 and place on isolation precautions on B unit and designated it the COVID Unit. The document indicated that the facility obtained COVID-19 testing kits on [DATE] and began testing residents on the B Unit. Results of those tests were given to the facility on [DATE], and 11 residents positive for COVID-19 were placed on droplet precautions. As of the week of ,[DATE]-,[DATE] there were no residents on the monitoring unit suspected or being monitored for COVID-19. The documented the week of ,[DATE]-,[DATE] the facility obtained additional COVID-19 testing kits on ,[DATE] and conducted testing that resulted in 37 residents with positive COVID-19 test results. Those 37 residents were placed on droplet precautions on the B and C Units. The document stated that there were No residents on the Monitoring Unit that week. The week of ,[DATE] to ,[DATE] the C Unit was the COVID unit and the B Unit was the Monitoring Unit. The week of ,[DATE] to ,[DATE] rooms C ,[DATE] were the Monitoring Unit and rooms C ,[DATE] were the COVID Unit. The week of ,[DATE] to ,[DATE] the C Unit was the Monitoring Unit. The week of ,[DATE]-,[DATE] the facility had one staff member test positive for COVID-19 who worked on A Unit and the A Unit became a Monitoring Unit. Resident #303 According to Admission Record (printed [DATE]), Resident #303 was a [AGE] year-old male, admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to Census Report (printed [DATE]), Resident #303 expired at the facility on [DATE]. Resident #303 was admitted to room B,[DATE] on [DATE] and was changed to room A,[DATE] on [DATE]. According to Resident #303's physician orders, he had an order that read, Resident was assessed for symptoms of COVID 19 including fever, shortness of breath, cough, sore throat, chills/shaking , loss of tastes/smell, muscle aches, headaches confusion, nausea, vomiting and diarrhea with directions that said, every shift for monitoring (ordered [DATE]). He was prescribed [MEDICATION NAME] (antibiotic) every 12 hours related to pneumonia until [DATE] and [MEDICATION NAME] (cough syrup) four times a day for cough ordered the day after admission-[DATE]. A chest x-ray was ordered for Resident #303 on [DATE] and [DATE]. [MEDICATION NAME] (antibiotics) was ordered every 8 hours for pneumonia for 10 days (started [DATE] and completed [DATE]) and [MEDICATION NAME] (antibiotic injected into the muscle) was ordered on time only for pneumonia. Vital signs were ordered every shift for three days on [DATE]. Review of physician progress notes [REDACTED].#303 was admitted for rehab after coughing up blood and being diagnosed with [REDACTED]. Progress Note Dated [DATE] written at 22:49 stated, Resident alert and able to make needs known. Writer received report from afternoon nurse that resident temp is 102. Resident is currently being put into a private room on isolation for the safety of himself, other residents and staff. Resident has new order for Tylenol to combat the fever. Resident was given fresh water to stay hydrated and will be further monitored throughout shift. No cough or shortness of breath noted at this time. Resident now in room B21. Progress noted dated [DATE] at 23:32 said, received in bed this pm shift denies pain or discomfort temp monitored and is 98.1 at beginning of shift, resident has loss of appetite at dinner consumed ,[DATE]% encouraged fluids, resident assisted with pm care and adl's (activities of daily living) writer notified by assistant near end of shift that resident feels warm, temp checked and is 102.7, notified md (doctor) on call received Tylenol order, Tylenol given temp is decreasing and down to 100.7, followed protocol for fever , labs and chest x ray ordered resident moved to private room cont (continue) to monitor. Progress note Dated [DATE] at 22:46 said, resident moved back to room [ROOM NUMBER] bed 2 this am shift, received in bed this oncoming pm shift no distress pm medications and abt (antibiotic) given as ordered tolerated well no adverse reaction temp is 98.2. Progress note [DATE] at 7:18 am said, At 7:18 this morning [DATE] (Resident #303) was assessed. He had no respirations, no heart rate. deceased at 7:18 am. According to the facilities LTC (Long Term Care) Respiratory Surveillance Line List, Resident #303's symptom onset date was [DATE] when he presented with a fever and had a positive chest x-ray. The Line List indicated that his symptom resolution date was [DATE] and he was not included on the line list again for recurring or continued symptoms. According to facility document titled, (Facility Name) Infection Control Monitoring Map; Resident COVID-19 2020 Mapping (Dates) for weeks ,[DATE] to ,[DATE], No COVID Positive Cases were documented. The maps were not marked with any residents positive for COVID-19 on the COVID-19 Unit or any residents being monitoring on the Monitoring Unit during the weeks between ,[DATE] to ,[DATE] when Resident #303 exhibited signs and symptoms of COVID-19 (fever and respiratory symptoms). Resident #304 According to Admission Record (printed [DATE]), Resident #304 was a [AGE] year-old male, admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to Census List (printed [DATE]), Resident #304 was moved from C,[DATE] (his room since admission), to room C,[DATE] on [DATE]. On [DATE] he was moved to B,[DATE] and on [DATE] he was moved to room B,[DATE]. Resident #304 was admitted to hospice on [DATE] and expired on [DATE]. According to facility document titled, (Facility Name) Infection Control Monitoring Map; Resident COVID-19 2020 Mapping (Dates) for the week of ,[DATE] to ,[DATE], the B Unit was the COVID-19 Unit. Prior to the week of ,[DATE] to ,[DATE] the mapping (started [DATE]) documented no residents on COVID-19 Unit or Monitoring Unit. According to the facilities LTC Respiratory Surveillance Line List, Resident #304's symptom onset date was [DATE] when he presented with fever, cough, decreased oxygen saturation and a positive chest x-ray. No symptom resolution date was documented on the line list for Resident #304. According to Resident #304's Temperature Summary (printed [DATE]), he had a temperature of 99.0 on [DATE] and [DATE], 99.3 on [DATE], 99.6 on [DATE], 99.0 and 101.2 on [DATE], 99.3, 104, 104.4, 103.8, and 103 on [DATE], 102 on [DATE], 101.6 on [DATE], 100.8 and 100.0 on [DATE], 100.2, 105.7, 103.2, and 102.1 on [DATE], 100.7, and 99.0 on [DATE], 100.1 and 101.0 on [DATE]. There was no documentations on in

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235547	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEPOINTE SENIOR CARE AND REHAB CENTER, L L C	37700 HARPER AVENUE CLINTON TOWNSHIP, MI 48036

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) his progress notes or on the facility line listing that addressed his low grade fevers in mid-end of [DATE]. Review of progress notes revealed room change on [DATE] at 03:26, but did not document the reason for the room change. On [DATE] at 09:43, progress note explained, Resident's responsible party was notified of the unit being closed due to safety concerns and isolation precautions. On [DATE] at12:50 PM, progress note said, Actively assessed resident for symptoms of a respiratory infection, AEB (as evidence by): fever, cough, shortness of breath, or sore throat. Resident displayed fever starting at 99.3 spiked up to 104. then up to 105.9 Tylenol was given cool cloth and ice packs applied to resident recheck at 104.4. Doctor aware, stat labs and covid swab ordered. Resident having non-productive cough, chest x ray ordered, spo2 (blood oxygen level) at 86% (below 90% is abnormal) room air, o2lnc (oxygen via nasal cannula) applied spo2 up to 94%. According to Lab Results Report, Resident #304 was tested for COVID-19 on [DATE]. The lab received the specimen on [DATE] and results were reported positive for COVID-19 on [DATE]. According to Resident #304's physician orders [REDACTED]. He also had an order for [REDACTED].#304 was prescribed Tylenol (fever reducer), [MEDICATION NAME] intramuscularly (antibiotic for infection), Zinc, [MEDICATION NAME], and [MEDICATION NAME] (for [MEDICAL CONDITION] infection) and Oxygen 2 liters via nasal cannula. A phone interview was conducted with the Administrator on 6//,[DATE], inquiring if there were any diagnosed COVID positive residents residing in the facility and he indicated there were no positive COVID residents at that time. An initial observational tour was completed in the facility on [DATE], after screening by receptionist at the main entrance. The screening involved filling out a questionnaire, temperature taken, and hand washing performed. During the initial tour, the Director of Nursing indicated recently 2 of her staff members had resigned from their positions and verbalized it was the Facility Educator and previous Infection Control Nurse. The DON indicated she was responsible for the management of Infection Control responsibilities. The DON verbalized there were no positive diagnosed residents currently residing in the facility at that time for COVID, but they had an outbreak, April and [DATE], she wasn't sure of the exact dates. The DON verbalized that hallway A is where most Long Term Care residents are residing, B hallway is the Rehab unit, and Hallway C is the monitoring unit for new admissions, suspected COVID residents and previously was the COVID unit. Staff were observed wearing Personal Protective Equipment (PPE) at that time. This Surveyor toured hallway C monitoring unit, with Nurse D, after donning PPE, before entering the monitoring unit. This included gown, N-95 mask, face shield and gloves, after hand washing. Tour of the monitoring unit was performed after entering double closed doors that separated the monitoring unit from the rest of the facility. Doors were closed to some rooms and signage was posted on several resident doors to indicate monitoring for respiratory symptoms. Any residents observed out of their room at that time were observed with facial coverings on. One Nurse and one Nursing assistant observed working on the unit during the tour and were wearing full PPE. Observation of PPE stock revealed no shortage during that time. At the end of the tour, in a designated room, near the separated doors, Nurse D, and this Surveyor removed PPE, performed hand washing, put on a clean gown, clean N-95 mask, face shield, and left the monitoring unit and went back into the rest of the facility. During the tour, Nurse D was asked if they had COVID spread through the facility and indicated that lots off staff had contracted [MEDICAL CONDITION] and many residents had been affected by COVID. Nurse D also verbalized the facility was doing much better now, than in the early days of the outbreak. It was pretty rough and scary in the beginning This Surveyor then spoke with the DON, who did not tour the monitoring unit, with Nurse D and Surveyor requesting documents needed for the survey and remote access. Surveyors exited the premises. A phone interview was conducted on [DATE], with Nurse K related to management of COVID in the facility. Nurse K verbalized that many residents and staff got sick with COVID while in the facility, and indicated it was because staff did not receive PPE until April, and said they should have received PPE in March when all the cases started popping up all over the area and in the community. Nurse K indicated that PPE was not provided until at least Mid-April and said it was too late, and verbalized there were positive cases and suspected cases for COVID in the building before Mid-April, and that PPE was not provided before the cases of COVID was present in the facility. Nurse K said that many staff were out sick. Unit Managers were out sick. The DON was out sick, and a lady from Corporate came to the facility to help and would put orders in, get labs and drive them to where they were going and other things. Nurse K said that N-95 masks were not provided to staff until Mid-April. Nurse K verbalized that there were so many sick residents that halls B and C were COVID units at one point. Nurse K also verbalized a concern that the facility was moving residents off the COVID unit, or monitoring unit too soon, and not waiting the full 14 days. Nurse K indicated once the residents were moved to general population, they would start showing COVID signs and symptoms again and then moved. Nurse K also indicated some residents were not tested before being moved and felt that was a big concern. Us nurse's and nurse aids voiced our concerns to the DON about PPE and we were told we did not need it. This was in March when all the notifications about COVID were everywhere. A phone interview was conducted on [DATE], with Nurse E related to management of COVID in the facility. Nurse E verbalized that PPE was not initially provided until April, and indicated it should have been provided sooner, such as March. We are in a zone where it is considered a hot spot and all around us. We did not get PPE until sometime in April. A phone interview was conducted on [DATE], with Nurse F who was asked about how the facility managed COVID. Nurse F verbalized that no testing had been completed in the facility until end of April and there were Residents in the facility in March that were showing signs and symptoms of COVID. Nurse F verbalized she had been exposed in the facility by a resident in March or early April and voiced concerns to the DON. Nurse F verbalized that proper PPE was not provided until late in April. We beg the upper management for proper PPE and they said we did not need it. The facility was not testing residents in March and there were several resident who were symptomatic. Nurse F indicated they had staffing problems and nurses were working up to 16 hour shifts. Nurse F went on to say that when PPE was provided in late April, it was taken away from them at some point because they said we did not need it. The positive Resident was not in the facility anymore, so they were telling us we had no positives cases in the building, and that we did not need the PPE. The positive resident was now at the hospital. They should have given us the proper PEP in March and never have taken it away, or made us beg for the PPE. A lot of staff got sick. A lot of residents got sick too. A phone interview was conducted on [DATE], with Nurse G related to the management of COVID in the facility. Nurse G indicated she had some concerns and verbalized about a specific resident who was symptomatic in March and that he was in a room with another person and was not moved. I brought my concern to a unit manager who took it up the chain and we were told not to worry. This resident had a cough and spiked a high fever but nothing was done. This was in early March and we were not given PPE until mid to late April. They said we did not need it. Us staff suspected COVID was in the building, but we were being told that no positives were in the building, however, they were not testing anyone for COVID. They were doing chest x-rays and flu tests, but not for COVID. We questioned that and suspected COVID on several residents. We were provided PPE in late April. I went home came back to work couple days later and all the PPE was gone. It had been removed. We asked why and was told we did not need it. At one point it was locked up in the DON's office. The facility said we were hoarding it, but that was not true. Staff were scared of getting COVID and dying from it. They never said they were going to remove the PPE, they just did it. All the face masks were removed from the carts without telling us why. A lot of staff felt like the facility was lying to us about positive COVID cases, and not sharing the important information needed. Several staff threatened to quit, and some did. We went to the Administrator. He said there was nothing he could do. Several staff called Corporate complaining about what was going on in the facility. The first COVID case was on the B hall which was the COVID unit at that time. They held a meeting with the B unit staff only and did not share information with the whole facility when the first positive COVID case was present in the building. I found out thru a co-worker telling me. One of the Housekeepers working on the COVID unit got sick from COVID. They were telling the B unit workers not to worry because the positive resident was sent out, so there were no positives in the building, and PPE was not needed. One of the residents who was sent out to the hospital showing COVID signs and symptoms returned to the facility with a positive [DIAGNOSES REDACTED]. The facility withheld PPE, provided some, then took it all away later, locked it up, and did not provide us with important information. On [DATE]th, they told us of the first positive COVID case in the building. They started doing some testing in the building and waited for the test results to come back and that was [DATE]th. Several staff were asking why some residents were not being tested and was told it was not necessary. A meeting was held in the facility for afternoon shift only for the B unit after the first case of COVID. They did not include the rest of the building. No PPE was provided before that time. It was the Corporate Nurse that helped to get us PPE. Many staff were angry and still are. Many staff got sick from this that maybe would not have. A phone interview was conducted on [DATE], with Nurse J related to management of COVID in the facility. Nurse J was asked if the facility provided PPE to protect residents and staff from COVID. Nurse J indicated that PPE was not provided until late in the game, around Mid-April. Nurse J verbalized that Ms Ross (DON) was asked for PPE and said it was not needed because

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235547	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEPOINTE SENIOR CARE AND REHAB CENTER, L L C	37700 HARPER AVENUE CLINTON TOWNSHIP, MI 48036

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 2) there were no COVID in the building. Nurse J said that they were sending a lot of residents out of the building to hospital in March, and early April that were having severe respiratory signs and symptoms, and found to be positive for COVID once tested in the hospital. We questioned upper management for protective equipment and the response was that there were no positives in the facility. This was the excuse we kept getting. They were telling us, unless there was a positive in the building, it did not count and those residents were in the hospital and not in the building. The facility was not being transparent with information about positive residents and withheld information. They did not provide us PPE in the beginning, took it away, locked it up and then gave it to us later. It was too late at that time, and very stressful. The yellow tag on doors for residents was removed too. They told us staff was stealing the PPE, but that was not true. They gave us PPE late in April. We received gown, goggle, Surgical mask, one N-95. The N-95 was reused for 2 weeks unless the strap broke or it was soiled. A phone interview was conducted on [DATE], with Staff R who voiced concerns about working on the COVID unit hall B and not having enough PPE to be protected or protect residents. Staff R indicated they had contracted COVID while working the facility. Staff R indicated there were no gowns or masks provided to them to wear while cleaning the unit. In the end when they did put out PPE, by the time I came to work, It was all gone. If you worked after hours when upper management was gone or on the weekend, there was no PPE available to use. I got very sick and so did a lot of other people. A phone interview was conducted on [DATE], with Nursing Assistant I related to COVID in the facility. Nurse Aid I verbalized that the facility could have done a better job on how COVID was managed. Nurse Aid I verbalized that residents would get moved to the COVID unit, and then moved off the unit after 5 days to regular unit, and then have to move them back to the COVID unit because they were showing signs and symptoms of respiratory problems. We were only provided PPE a little over a month ago with the N-95 mask and it is rotated out now. We were not provided PPE until late in April. I was off work with signs and symptoms of COVID for ,[DATE] weeks. I tested negative, but still had symptoms, so I was off work. I know I picked it up at work. The upper management knew we had positive cases in the facility and was telling us Staff on A unit that our unit was clean, but we still had a lot of sick people on the unit. We were not always given the proper information at times and only certain staff were kept informed. Sometimes we were informed and sometimes we were not informed about COVID in the facility. When they had a positive case on the B unit, they did not tell the A unit. We heard it thru rumors from co-workers. At one point there were bins hanging on doors for certain sick residents with PPE. I would come back to work and all of the bins were removed. All the gowns would be gone. They left some stuff at the front desk, but that ran out too. Review of LTC (Long Term Care) Respiratory Surveillance Line List dated [DATE], completed and signed by DON, documented 7 Residents in March with signs and symptoms of cough, fever, as early as [DATE]th. Two residents with documented Shortness of Breath, and 1 resident with decrease on oxygen saturation. Further review of March Line List documented 7 residents had chest x-rays completed. Out of 7 symptomatic residents with respiratory signs and symptoms only one was tested for COVID, but not until [DATE], and was positive for COVID. Two residents with documentation of symptom resolution, were listed a second time with onset of respiratory signs and symptoms of Cough, and/or decrease saturation. According to the Line List, 3 residents were sent to the hospital, and 2 residents expired. A phone interview was Conducted with DON on [DATE], [DATE] and [DATE], inquiring about the first onset of respiratory signs and symptoms, the comprehensive total number of COVID cases in the facility for residents and staff to current. The DON indicated there had been 71 cases of COVID in the facility with census of 112, with 30 positive staff, and 33 additional staff out sick with respiratory signs and symptoms (total of 63), and 26 deaths. The DON was asked to provide the data for Facility Acquired cases and Community Acquired cases, by the end of survey did not provide the data. The DON indicated that 6 deaths from COVID occurred in the facility and 20 deaths occurred in the hospital when the facility sent them out. The DON was asked if there was ever a time when the facility did not have access to testing kits, or the ability to test residents in the facility for COVID and initially indicated there was not a time of lack of testing capabilities. The DON was asked when her first onset case of COVID occurred in the facility and indicated not until April. The DON was asked about the symptomatic residents with documented respiratory signs and symptoms in early March (14th) and indicated those residents with positive chest x rays received treatment for [REDACTED]. The DON was asked why and indicated the facility was not testing at that time. The DON verbalized that she had been off work sick from [DATE] through [DATE], and that Regional Director of Clinical was in the building helping with Infection Control. The DON was asked if there was ever a time when they were low with PPE and said No, and verbalized the facility never went without PPE. The DON verbalized there was a full out break of COVID in April and PPE was provided at that time. The DON was asked about the early symptomatic residents showing signs and symptoms of COVID in early March and verbalized the Doctor did net feel that the residents that were having respiratory signs and symptoms were related to COVID. The ones that had pneumonia were treated with antibiotics. The DON was asked if there was any correlation of the number of staff positive for COVID and the numbers of affected residents and verbalized she was not sure. The DON was asked if staff asked for PPE and said yes, but it was before our first positive case and they did not need it. The DON was asked if there was ever a time that PPE was provided and then removed and said staff were stealing PPE and it was placed in the DON's office. The DON verbalized that N-95's were not provided until the first positive COVID case was in the facility. The DON verbalized that in the beginning of all of this, PPE was put in the emergency cart, and due to reorganizing PPE, it was removed from the emergency cart, and placed in one location to keep tract of it. It was originally in Central supply and staff were hoarding it and stealing it, so it was locked up in the DON's office. The DON later on verbalized there was limited testing capabilities in March. A phone interview was conducted 9:05 AM, [DATE], with Health Department Nurse H who was asked how the facility had maintained contact with the Health Department. Nurse H verbalized she had been assisting the facility in investigation of signs and symptom onset, exposure, and Persons Under Investigation for COVID. Nurse H was asked when the first date the DON was in contact with the HD related to COVID residents, and indicated that DON never reached out to the HD initially, it was the HD that reached out to the facility by coming across an employee positive for COVID 19. Nurse H indicated that the facility was sending residents to the hospital who were suspected for COVID. The Attending was trying to manage the suspected residents 'in-house' and if the facility couldn't manage the residents, they were sent to the hospital. Nurse H verbalized she had stumbled across the positive staff member from a Micker CDC report and reached out to the facility to inform them that they had a positive employee. Nurse H verbalized that was how contact had been established. Nurse H also indicated the DON had been off sick for couple of weeks and she had regular contact with the Corporate Nurse O who was in helping the facility. Nurse H indicated it was [DATE], that she informed the facility of the positive employee. Nurse H was asked if she was aware of the numbers of affected residents and staff to current. Nurse H indicated that the census was around 118 residents in the facility and she knew approximately 71 residents had been affected with 26 deaths, 63 affected staff. Nurse H indicated the data was getting sent faxes by Corporate Nurse O. Nurse H verbalized the last data received from the facility was [DATE], a few weeks back. Nurse H indicated another staff member at the HD had taken over managing the Facility with COVID, and Nurse H was not able to see any additional data in the notes provided by the new staff member or by the facility for past few weeks. Nurse H verbalized she thought the facility had some break down in Infection Control Practices is why the numbers were so high. Nurse H also verified that the facility had another positive staff for COVID as recent as two days ago. Nurse H indicated she had seen the spike in COVID residents and staff in mid April during one week period while the DON was off sick and did not hand off any information to Corporate Nurse O. I had to catch Corporate Nurse O up on what was going on and it took about a day to gather information, and at that time they were suspicious of everyone. Nurse H went on to say that the building became overwhelmed at one point and trying to perform testing and figure out who was sick and who was not. There were so many sick residents and staff at that time in Mid-April. Nurse H verbalized that Corporate Nurse O began sending weekly logs at that time and regular contact. Nurse H indicated the facility never asked about testing, but notify the HD they needed PPE. Nurse H verbalized on [DATE], they indicated they could use test kits and Ms Ross came and got 20 tests. CDC, Long-Term Care (LTC) Respiratory Surveillance Line List, [DATE], 'The Respiratory Surveillance Line List provides template for data collection and active monitoring of both residents and staff during a suspected respiratory illness cluster or outbreak .Using this tool will provide facilities with a line listing of all individuals monitored for or meeting the case definition for the outbreak illness . Each row represents an individual resident or staff member who may have been affected .The information .capture data on case demographics, location in the facility, clinical signs/symptoms, diagnostic testing result outcomes .'Information gathered on the worksheet should be used to build case definition, determine duration of outbreak illness, support monitoring for rapid identification of new cases and assist with implementation of infection control measures . A phone interview was conducted with Nurse Practitioner M on [DATE] at 9:59 AM, related to how facility was managing residents symptomatic for COVID-19. Nurse Practitioner M verbalized there was some symptomatic residents with Respiratory signs and symptoms in Mid-March and early April, and testing depended on what the building was doing at that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235547	A. BUILDING _____ B. WING _____	**06/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEPOINTE SENIOR CARE AND REHAB CENTER, L L C	**37700 HARPER AVENUE CLINTON TOWNSHIP, MI 48036**

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 3) time. NP M indicated that the facility was not testing early on. NP M verbalized their Policy as providers was to treat all residents as if they were positive for COVID way back in March. NP M indicated that if a resident was suspected for COVID, they should go in isolation, preferably a private