STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235480	A. BUILDING _____ B. WING _____	07/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANTAGE LIVING CENTER - HARPER WOODS	19840 HARPER AVE HARPER WOODS, MI 48225

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 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 properly maintain infection control practices including implementation of comprehensive tracking and documentation of infections including signs and symptoms of infections and implementation of isolation precautions and Personal Protective Equipment (PPE) use for four (#'s 701, 703, 705, and 707) of five Residents reviewed for infection control during a COVID-19 Infection Control Survey resulting in lack of documentation of infection control surveillance and tracking data and the likelihood for spread of infection. Findings include: An interview was conducted with the facility Administrator on 7/28/20 at 9:45 AM. When queried regarding current Covid-19 infections within the facility, the Administrator revealed one person (Resident #701) was currently in the facility Covid-19 unit. With further inquiry regarding Resident #701, the Administrator revealed the Resident had went to the hospital and the Covid-19 test they had at the hospital was positive. The Administrator further revealed, (Resident #701) has pneumonia too. When asked where the Covid-19 unit was located within the facility, the Administrator replied, Willow South. The Administrator then stated, The Covid unit is behind the observation unit for signs and symptoms (Willow South). All of North (Willow) is observation for admissions and readmissions. The Administrator was then asked what PPE is required to be worn by staff in the Willow observation units and replied, Gloves, gowns, and masks. When queried what PPE was required for staff providing care to Residents in the designated Covid unit of the facility, the Administrator stated, Mask, gown, gloves, and eye protection if doing direct care. When queried who the facility Infection Control nurse was, the Administrator indicated the Director of Nursing (DON) was the acting Infection Control Nurse. All facility infection control data from 5/30/20 to 7/28/20 was requested from the Administrator at this time. A tour of the facility designated Covid Signs and Symptoms unit began on 7/28/20 at 10:25 AM. There was no signage noted upon entering the Willow unit of the facility to indicate the unit was a designated isolation area. The following observations occurred of occupied Resident rooms: -room [ROOM NUMBER]: One Resident, Isolation Precaution sign on room door and PPE cart outside of door. The room door was open. -room [ROOM NUMBER]: Two Residents in the room with privacy curtain open between the Resident's beds, Isolation Precaution sign on room door and PPE cart outside of door in-between this room and room [ROOM NUMBER]. The room door was open. -room [ROOM NUMBER]: Two Residents in the room with privacy curtain open between the Resident's beds. No signage present indicating the Residents were on isolation precautions. The room door was open. -room [ROOM NUMBER]: Two Residents in the room with privacy curtain open between the Resident's beds. No signage present indicating the Residents were on isolation precautions and no PPE cart near the door of the room. The room door was open. -room [ROOM NUMBER]: One Resident. No signage present indicating the Resident was on isolation precautions and no PPE cart present near the door of the room. The room door was open. At the end of the designated Covid Signs and Symptoms unit of the facility, the hall doors were closed with a stop sign on the door. The sign stated, See Nurse before entering. No PPE was noted at the entrance of the unit. Upon looking through the glass panels of the closed doors, no facility staff were present in the hallway. An interview was conducted with Licensed Practical Nurse (LPN) A on 7/28/20 at 10:35 AM. When queried regarding placement of Covid Residents within the facility, LPN A stated, Rooms 76 to 90 on (Willow) South are for Covid (confirmed positive). When queried if any Residents were positive for Covid and in the designated Covid-19 unit, LPN A revealed Resident #701 was the only Resident currently in the unit. LPN A was then asked about the Resident's Covid status who were on the Willow South unit prior to entering the Covid unit, including rooms 64, 66, 68, 72, and 74, and replied, This is the signs and symptoms unit. LPN A then stated, (Willow) North is for when people come back from the hospital. At 10:40 AM, a female Resident was observed self-propelling themselves from the Willow North hall of the facility towards the nurses' station without a mask. When asked about the Resident and facility policy/procedure pertaining to Residents in central areas of the facility, LPN A revealed the Resident was from the Admission unit (Willow North) and should have a mask. A tour of the Willow North, facility designated admissions/readmissions unit began on 7/28/20 at 10:45 AM. The unit was open and there was no signage present indicating the unit was a quarantine area for admissions to the facility. A male Resident was observed in the hallway. The Resident was self-propelling themselves in a wheelchair and was not wearing a mask. During the tour, a PPE cart was noted outside of room [ROOM NUMBER] but the room did not have a precaution sign on the door. On 7/28/20 at 10:50 AM, an interview was conducted with LPN C. When asked, LPN C indicated they were assigned to the Willow North Unit of the facility. When queried regarding Resident's residing on the Willow North unit of the facility, LPN C revealed the unit was for new and readmitted Residents to the facility. LPN C was then queried regarding facility policy/procedure pertaining to Residents on the Admissions unit and replied, Do Covid sign and symptom screenings. When queried regarding isolation and/or PPE requirements on the unit, LPN C revealed there were two Residents with isolation precautions in place. When asked, LPN C revealed the Residents with isolation precautions were in rooms [ROOM NUMBERS]. When queried if Residents who are on isolation precautions are supposed to have signage on their room door per facility policy/procedure, LPN C replied, Yes. When asked why there was not a sign on room [ROOM NUMBER]'s door, LPN C stated, There should be. I will get one. No further explanation was provided. At 10:55 AM on 7/28/20, Resident #703 was observed sitting in the hallway of the signs and symptom unit of the facility in a wheelchair. The Resident's wheelchair was positioned next to their room door and Restorative Nursing Assistant (RNA) B was standing in front of the Resident guiding them in restorative therapy. An interview was conducted with the Resident at this time. When queried if they had been coughing, Resident #703 replied, Yeah. With further inquiry, Resident #703 indicated they were receiving [MEDICATION NAME] (steroid nasal spray used to treat nasal congestion) and stated, It doesn't help with the cough. It just runs down my throat. At 11:04 AM on 7/28/20, Respiratory Therapist D was observed entering the dedicated Covid unit of the facility without donning PPE and/or performing hand hygiene. No PPE and/or hand hygiene equipment was available directly outside the entrance area of the unit. Upon observation of the unit, through the glass windows in the doors, Respiratory Therapist D and LPN E were observed in the hall. Both staff members were wearing a mask but no other PPE. The Covid-19 unit of the facility was entered at this time. Upon entering the unit, no PPE and/or hand hygiene equipment were available upon entrance. A tour of the unit was completed at this time. Resident #701's room door was open and they were observed laying in bed on their back. An indwelling urinary catheter drainage bag was positioned on the right side of the bed and was visible from the door. The catheter drainage bag was noted to be positioned so that it was directly touching the floor. Within the Resident's room, near the door, a linen cart was present. The only garbage can observed in the room was positioned directly next to the Resident's bed. A PPE cart was present outside of the Resident's room in the hall. The PPE cart contained gloves, washable gowns, and portable blood pressure monitors. No hand sanitizer was present on the cart. An interview was conducted with LPN E on 7/28/20 at 11:08 AM. When queried regarding facility PPE requirements in the dedicated Covid-19 unit of the facility, LPN E stated, Gloves, gowns, eye protection, and masks. When asked where PPE is donned per facility policy/procedure when caring for Residents in the dedicated Covid-19 unit, LPN E stated, There is a designated room and opened a Resident room door (room [ROOM NUMBER]). The room did not have a Resident in the room and there was a hanging rack with a blue colored disposable gown with an employee name was written on the gown. No additional PPE was noted in the room. When queried

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) regarding the PPE cart near the door of Resident #701's room, LPN E stated, I just gown up before I go in the room. When asked if they would don PPE in the hall if there were other Residents in the unit, LPN E indicated they would. When queried if the Covid unit hall is considered a clean area and if it has always been considered a clean area, LPN E did not provide a direct response. When asked how the hall was considered a clean area when used PPE was stored in the designated PPE area (room [ROOM NUMBER]), LPN E indicated they did not know. No further explanation was provided. LPN E was then asked if Resident #701 had signs/symptoms of Covid-19 and replied, (Resident #701) is congested and has a cough. They recently started spiking a low grade temp (temperature). LPN E then stated, (Resident #701) has a UTI (Urinary Tract Infection). When asked how PPE is doffed upon exiting the room when the only garbage can is located directly next to the Resident's bed, LPN E replied, I see what you're saying. LPN E was then queried where hand hygiene is performed upon exiting the room when hand sanitizer was not present at the exit of the room, LPN E indicated hand sanitizer was present on the medication administration cart in the hall. An observation of Resident #701 occurred with LPN E on 7/28/20 at 11:20 AM. LPN E did not wear eye protection upon entering the Resident's room. The Resident remained in the same position in their bed. The Resident's catheter drainage bag remained on the right side of the bed, directly touching the floor. The Resident's Foley catheter securement device was not attached to the Resident's leg and the catheter tubing was noted to be taut. When queried if catheter securement devices are supposed to be utilized per facility policy/procedure, LPN E indicated they were and stated, I will have to get a new one. A portable electronic blood pressure monitoring was observed in Resident #701's room. When asked if dedicated monitoring equipment was utilized for Residents with Covid-19, LPN E indicated it was. When queried if Resident #701 had a dedicated thermometer in their room, LPN E looked through the Resident #701's room and revealed the Resident did not have a thermometer in the room. When asked how they monitor the Resident's temperature, LPN E stated, I have a touch-less one. LPN E was then observed doffing their PPE upon exiting the Resident's room. LPN E did not perform hand hygiene upon exiting the room. With further inquiry regarding the thermometer used to monitor Resident #701's temperature, LPN E revealed they use their personal thermometer which they keep in their fanny pack around their waist. When asked to see the thermometer, LPN E opened their fanny pack and revealed they did not have it with them. LPN E was then queried if they wore eye protection when they entered Resident #701's room and replied, I did not. When asked why they did not wear eye protection when they had previously stated eye protection needed to be worn per facility policy/procedure, LPN E indicated they forgot and stated, It's on the cart (medication cart). When queried regarding Resident #701's catheter drainage bag being positioned directly on the floor, LPN E stated, Oh, it is. I'll have to fix that. LPN E was then asked if catheter drainage bags are supposed to be positioned directly on the floor, per facility policy/procedure, and indicated they were not. Hand hygiene equipment was not available directly before or exiting the Covid unit to the facility Covid Signs and Symptoms unit. After exiting the Covid-19 unit, LPN E entered an office located next to the entrance of the Covid unit and obtained a thermometer from a personal bag. The thermometer was an unknown brand and had their name written on it. When asked how they cleaned the thermometer after use and before exiting the unit, LPN E indicated they wipe the thermometer with a cleaning wipe. Resident #703 remained sitting in their wheelchair in the hall of the Signs and Symptoms unit of the facility upon exiting the Covid unit on 7/28/20 at 11:30 AM. An interview was conducted with LPN A on 7/28/20 at 11:35 AM. When queried regarding facility policy/procedure pertaining to Resident's on the Signs and Symptoms unit being in the hallway, LPN A replied, Shouldn't be. When asked what PPE should be worn by staff upon entering Resident rooms on the Signs and Symptoms unit, LPN A stated, All of it, like for Covid. When queried if all Residents on the unit had precautions in place, LPN A indicated they were. When asked if isolation precaution signs should be in place and visible at the outside of the Residents room to indicate they are on isolation precautions, LPN A replied, Yes. When asked why isolation precaution signs were only present on two of the five occupied rooms, LPN A was unable to provide an explanation. On 7/28/20 at 11:40 AM, an interview was completed with LPN A and RNA B. RNA B was asked if Resident #703 was on isolation precautions and replied, Yes. When queried regarding observation of Restorative Nursing for Resident #703 in the hall of the Signs and Symptoms unit and facility policy/procedure regarding the Resident's on the unit being out of their rooms, RNA B stated, They (administration) told me (Resident #703) could. With further inquiry, LPN A revealed they were unsure why the RNA B was told the Residents could be in the hall and they would need to look into it because that was not their understanding. No further explanation was provided. An interview was conducted with the Director of Nursing (DON- Infection Control Nurse) on 7/28/20 at 12:05 PM. When queried regarding PPE required on the Willow South unit of the facility, the DON stated, Those are the sign and symptoms (Residents). Gloves, gowns, masks, regular PPE. When asked if isolation precaution signs should be present on the entrance to the Resident doors on that unit, the DON replied, Yeah, but I just got back from vacation and indicated they were not aware if the Resident's precautions were being discontinued. When asked if the Resident's assigned nurse should be aware if precautions were discontinued as LPN A was not aware, the DON replied, The Nurse would have been aware. The DON was then asked what PPE was required to be worn in the dedicated Covid unit of the facility and replied, Mask, gown, gloves, eye protection. When queried where staff don PPE upon entering the Covid unit, the DON replied, There is a room that they are putting their stuff (PPE) on. The DON was asked if the room they were referring to was Resident room [ROOM NUMBER] and they indicated it was. When queried regarding facility policy/procedure pertaining to use of vital sign equipment, including thermometers, for Residents with Covid-19 the DON stated, Every room should have own equipment. When queried regarding observation of LPN E not wearing eye protection in Resident #701's room, the DON did not provide an explanation. The DON was then queried if urinary catheter drainage bags should be touching the floor, per facility policy/procedure, and replied, No. When asked if urinary catheter securement devices are supposed to be in place and secured to Resident's with catheters, the DON replied, Yes. When asked about observations of Resident #701's urinary catheter and drainage bag, the DON did not provide further explanation. Review of facility provided documentation of infection line listings from 5/30/20 to 7/28/20 revealed eight Residents had been diagnosed with [REDACTED].#701 and/or any of the Residents currently on the Signs and Symptoms unit of the facility. A list of all Residents and staff who had been positive and/or had signs and symptoms of Covid-19 from 5/30/20 to 7/28/20 was requested from the facility Administrator on 7/28/20 at 12:23 PM. Review of requested list revealed seven Residents had been positive for Covid and five Residents had signs and symptoms of Covid-19. The five Residents listed as having signs and symptoms of Covid-19 were all located on the Signs and Symptoms unit of the facility. The additional three Residents located on the Signs and Symptoms unit were not present on the list, including Residents who were in a shared room with Residents listed as having signs and symptoms. Resident #701 was also not included as having Covid-19 on the provided list. An interview was conducted with the DON on 7/28/20 at 1:21 PM. When queried regarding Resident #701 not being included on the facility provided infection line listing and/or the list of Residents diagnosed with [REDACTED]. You're right. When asked if Resident #701 should be included on facility infection tracking and surveillance data, the DON replied, Yes, (Resident #701) came back from the hospital with positive Covid. When asked why Resident #707 was on the line listing but not on the other provided Covid-19 Resident list, the DON indicated the Resident must have been missed. When queried regarding the inconsistency noted in the number of Residents diagnosed with [REDACTED]. The DON was then asked why Resident #703 was not present on the infection line listing and how the facility was tracking other Residents with signs and symptoms of Covid-19. The DON replied, The Infection Control person was supposed to be being tracking signs and symptoms. I wasn't doing it. When asked for clarification regarding who was completing and/or responsible for infection control within the facility, the DON replied, We hired an ADON (Assistant Director of Nursing) to do it but they quit. They weren't here long. When asked how long that employee was completing infection control, the DON indicated they were unsure and would need to contact the Administrator. The provided list of Residents with signs and symptoms of Covid-19 was reviewed with the DON at this time. When asked why three Residents currently on Covid Signs and Symptoms unit were not on the provided documentation, the DON stated, No, they (Residents) are not all on there. When asked if the Residents should be included in the infection control tracking documentation, the DON revealed any Resident with signs and symptoms of infection, including Covid-19, should be included. When asked how many Residents have had signs/symptoms of Covid-19 and were not included in facility infection tracking documentation, the DON stated, There is no way to tell. The Administrator joined the interview at this time and the previous infection control staff was employed from 6/5/20 until 7/20/20. When asked who was covering infection control from 7/20/20 until 7/28/20, when the DON returned from vacation, the Administrator stated, (Registered Nurse (RN)F) and myself. Upon request, RN F joined the interview. When queried regarding the process for infection control surveillance and data tracking after the ADON left employment at the facility and the DON was on vacation, RN F revealed they were completing it along with the Administrator. When asked how they were made aware of new infections, RN F stated, We get notifications on the computer that we discuss in our morning meeting. With further inquiry, RN F revealed nursing staff enter documentation on the electronic medical record which is then reviewed. When queried if they entered the infection

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) control data on facility infection tracking documentation, RN F stated, I wasn't. The Administrator was then asked if they entered infection data on the facility tracking and surveillance documentation and replied, I'm sure I missed some. Review of facility provided non-Covid infection control data for June and July 2020 revealed no documentation of mapping for Residents with Covid-19 and/or signs/symptoms of Covid-19. The infection control data revealed four out of eight Residents residing on the Covid Signs and Symptoms unit were not listed on the non-Covid infection control data. Review of the data further revealed six Residents with respiratory symptoms with an outcome of No Infection after receiving antibiotic therapy. The facility non-Covid infection control data was reviewed with the facility Administrator on 7/28/20 at 2:40 PM. When queried regarding inconsistent tracking documentation and lack of mapping for Covid-19 infections, the Administrator revealed they understood the concerns but did not provide further explanation. Resident #701 Review of Resident #701's medical record revealed the Resident was most recently readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required extensive to total assistance to perform Activities of Daily Living (ADLs). Review of Resident #701's medical record revealed the Resident had an intermittent low-grade temperature beginning on 7/11/20. Resident #701's documented temperature on 7/28/20 at 11:02 AM was 99.2 degrees Fahrenheit (F). The medical record further revealed Resident #701 had an order in place for isolation precautions related to positive Covid-19 infection. Resident #703 Review of Resident #703's medical record revealed the Resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the MDS assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required extensive to total assistance to perform ADL's. Record review of Resident #703's medical record revealed the Resident had an order for [REDACTED].#705 Review of Resident #705's medical record revealed the Resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required limited to extensive assistance to perform ADLs. Resident #707 Record review revealed Resident #707 was most recently admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #707's Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required limited to extensive assistance to perform Activities of Daily Living (ADLs). Resident #707's medical record further revealed the Resident had tested positive for Covid-19 on 7/9/20. Review of the facility provided policy/procedure entitled, Infection Prevention and Control Program Overview (no date) revealed, The infection prevention and control program is designed to identify and reduce the risk of acquiring and transmitting infections among residents, staff, volunteers, students, and visitors. The program incorporates a broad range of education, surveillance, prevention, and infection control practices involving all departments and is managed by the designated infection preventionist under the guidance of the Infection Preventionist . Infection prevention and Control Program Elements consist of: Surveillance based on systematic data collection to identify nosocomial infections . A system for the detection, investigation, analysis and planning to prevent and control institutional outbreak of infectious diseases . An isolation/precaution system to reduce risk of transmission of infectious agents . Infection control policies and procedures . A system for antibiotic review and control and antibiotic stewardship On a monthly basis evaluate the last quarter for possible trends compare the current month results to 1 year ago . Review of the facility provided policy/procedure entitled, Management of Outbreak of Communicable Diseases (no date) revealed, Outbreaks of communicable diseases within the facility will be promptly identified and appropriately handled . An outbreak is typically one or more of the following . One case of an infection that is highly communicable . Occurrence of three or more cases of the same infection over a specified length of time on the same unit or other defined areas . Review of the facility provided policy/procedure entitled, Covid-19 Interim Pandemic Guidelines (Updated July 1, 2020) revealed, The nursing staff will be responsible for: Monitoring residents and other team members for symptoms of infections. Notifying the Director of Nursing, Infection Preventionist and physician of symptomatic residents; Providing infection surveillance data in a timely manner . Initiating isolation barriers as directed or as necessary .If a current resident begins showing S/S (signs/symptoms) and you suspect COVID-19 you should place in droplet or contact precautions and notify the physician and local health department . Confining symptomatic residents to their rooms . Symptomatic Resident Identified: Isolate the individual into a private room, cohorted with like resident or unit designated for residents with symptoms to avoid potential cross contamination with other residents. Place in contact/droplet precautions. Notify the attending physician. Contact your local health department (LHD) to report the symptoms. Contact the resident/responsible party. In conjunction with the attending physician and LHD determine the need for testing and make arrangements if indicated . Increase resident monitoring for signs & symptoms or change in condition to once per shift .Resident Tests Positive . Increase resident monitoring for signs & symptoms or change in condition to twice per shift . Identify staff members who have had close contact with the resident, identifying for 5 days prior to the onset of symptoms if possible . Mask these individuals. Monitor for onset of signs & symptoms .