STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235580	A. BUILDING _____ B. WING _____	07/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-ANN ARBOR	4701 E. HURON RIVER DR ANN ARBOR, MI 48105

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 maintain infection control practices to prevent potential transmission of COVID-19 by failure to: 1. Follow the Centers for Disease Control (CDC) guidance for social distancing (at least 6 feet) for facility staff. 2. Ensure appropriate Personal Protective Equipment (PPE) usage related to new admission quarantine residents and facility staff. 3. Ensure compliance with airborne isolation requirements, per facility policy, of new admission, readmission, and positive COVID-19 residents. These deficient practices resulted in the potential for the transmission for COVID-19 (a highly transmissible [MEDICAL CONDITION] infection), which had the potential to affect all 120 vulnerable facility residents. Findings include: On 7/8/2020 at 8:30 a.m., upon entrance into the facility to conduct an abbreviated survey, this Surveyor was notified by the Nursing Home Administrator (NHA) of one new positive, asymptomatic COVID-19 resident: Resident #10. Resident #10 was tested for COVID-19 on 7/6/2020 with positive results confirmed on 7/8/2020. No other positive residents were present in the facility. Review of Resident #10's Minimum Data Set (MDS) assessment, dated 2/6/2020, revealed Resident #10 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #10 scored 8 out of 15 on the Brief Interview for Mental Status (BIMS), reflective of moderate cognitive impairment, and required two-person assistance with bed mobility, transfers, dressing, and toilet use. On 7/ at 9:24 a.m., four new staff members were observed sitting shoulder to shoulder (not social distancing) during an orientation training. Registered Nurse (RN) C was sitting on the far right, and Certified Nurse Aide (CNA) D was positioned on the far left with two other trainees sitting in between them. RN D's facemask was placed on the table in front of her, and CNA D's facemask was hanging from her left ear, leaving her nose and mouth exposed. When asked about the lack of PPE (facemasks) RN C stated, It looks like we love each other .I was eating. She (Human Resources Director (Staff)) X said we could have snacks. All four trainees agreed social distancing (6 feet) was not maintain, and lack of facemasks created the potential for transmission of COVID-19. Staff X was not present in the room. During a telephone interview on 7/10/2020 at 8:50 a.m., when asked about social distancing and facemask usage during orientation training, Staff X stated, We set the room up in front of the TV with masks on. They were socially distanced if they had their facemasks on. They (all four orientees including RN C and CNA D) were instructed to keep their masks on .For eating you have to be six feet apart. That is a verbal facility policy . On 7/8/2020 at 9:25 a.m., Resident #9 was observed exiting his airborne isolation quarantine room without a facemask. Resident #9 carried, in his bare hands, a used (soiled) disposable foam meal container along with plastic cups and covers, that were placed directly on an overbed table outside of Resident #9's room. A red stop sign was placed next to the room door in a plastic sheet protector. Enclosed on the back side of the sheet protector, was an orange form that identified airborne precautions for Resident #9's room. Review of the form revealed the following: PRECAUTION INSTRUCTIONS: AIRBORNE PRECAUTIONS PPE Required: Gloves, N95 Mask, goggles or face shield with mask attached, gown . ISOLATION: YES. Review of the facility Transmission Based Precautions: Airborne Precautions, Issue Date: 5/2013, revealed the following: Airborne Precautions .Microorganisms carried in this manner can be widely dispersed by air currents and may become inhaled within the same room or over a longer distance depending on environmental factors . the following measures are necessary for airborne precautions .Wear N95 disposable mask when entering room of patient .Keep room door closed and patient in room . On 7/8/2020 at 9:40 a.m., when asked about Resident #9, RN E stated, He puts on a mask to come outside of the room. He should be staying in his room. RN E said Resident #9 had come from the hospital and was on airborne precautions. When asked about disposal of used meal containers/utensils, RN E stated, I think someone went in the room (to get the dirty meal containers). We throw it away. The soiled meal containers were observed, by this Surveyor, in the hall outside of Resident #9's room at this time. On 7/8/2020 at 9:43 a.m., Housekeeping (Staff) F was observed to remove an N95 mask from a brown paper bag. The N95 mask was placed on the cleaning cart with the front of the N95 mask in direct contact with the cleaning cart. Staff F removed her surgical mask and placed it in direct contact with the cleaning cart. Staff F wore the same goggles used to clean previous rooms (quarantine and non-quarantine) into Resident #9's airborne isolation room. Resident #9's room door remained open while Staff F cleaned inside the room. On 7/8/2020 at 9:50 a.m., after cleaning Resident #9's room, Staff F exited the room, removed her gloves, sanitized her hands, and removed the N95 from her face placing the N95 into the same brown paper bag. Staff F donned the previously used surgical facemask from the top of the cleaning cart. During an interview at this same time, when asked about repeated use of the N95 mask, Staff F said she received the N95 facemask about 2 weeks ago and has used it in all of the quarantine rooms that she is required to clean, since receiving it. Staff F touched the front of her surgical mask with her bare hand and stated, These (blue surgical masks) are disposed of daily. No hand hygiene was observed by Staff F following touching the front of the surgical mask donned. On 7/10/2020 at 8:39 a.m., Acting DON confirmed the facility presently had 21 residents who were on airborne quarantine precautions. On 7/8/2020 at 10:00 a.m., Temporary Nurse Aide - PCA (Patient Care Assistant) (Staff) G exited room [ROOM NUMBER]. Staff G returned to room [ROOM NUMBER] and performed handwashing. Staff G then collected the dirty garbage from room [ROOM NUMBER]'s garbage can, including items picked up from the floor with Staff G's bare hands. Staff G wore a mask with face shield but did not don gloves. Staff G touched the handle on the door of room [ROOM NUMBER] with bare, now dirty, hands as he exited the room with the garbage bag in his other bare hand. At 10:02 a.m., Staff G, using bare hands, picked up the soiled meal containers on the overbed table outside of Resident #9's room, and placed them into the garbage bag from room [ROOM NUMBER]. During an interview at this same time, when asked about removing the soiled containers from Resident #9's airborne isolation room with bare hands, Staff G stated there would be a concern with contamination. The potentially contaminated soiled meal containers had remained in the hallway for 37 minutes. During an interview on 7/8/2020 at 10:40 a.m., Food Services Director (Staff) N was asked about disposal of used meal containers from quarantine rooms. Staff N's face mask was below his nose, covering only his mouth. This Surveyor requested Staff N reposition his mask, to cover his nose, prior to continuation of the interview. Staff N stated, The used food containers do not come out of the room. We don't deal with that (used food containers from quarantine rooms) at all .They (staff) are not to pick up the trays. When asked if a quarantine resident should exit their room and place dirty meal containers in the hallway, Staff N stated, That would be wrong I, 200 percent, agree with you. The resident should not have brought it out himself. Normally we keep the door shut. During a repeat interview on 7/8/2020 at 3:05 p.m., Staff N reviewed the Meal Service for Isolation Units - Guidelines with this Surveyor. Staff N stated, No, this (policy) is not what we are doing. It (used meal trays/containers) doesn't come back into (the dirty tray) cart. Everything is thrown away . Everything is disposable - everyone knows it. On 7/8/2020 at 10:05 a.m., and 10:06 a.m., respectively, CNA I was observed wearing an N95 mask with an exhalation valve and a face shield, and CNA K was observed wearing an N95 with an exhalation valve over a blue surgical mask, and goggles. Both masks were labeled with (Brand Name) 8511. When asked about the N95 masks, both CNA's confirmed they were the masks provided to them approximately two weeks before, during the N95 fit testing, and these masks were worn into every quarantine room they were required to provide care in, during the previous two weeks. CNA K was unaware the surgical mask was not to be worn underneath the N95 mask. CNA I and CNA K were observed on the 500 hall, where

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) newly identified COVID-19 positive Resident #10, was residing. On 7/8/2020 at 10:15 a.m., Resident #10's (asymptomatic, positive for COVID-19) room door was observed open in the presence of RN/Unit Manager J. RN J said Resident #10 was in airborne precautions (isolation), and the room door should be shut. RN J attempted to shut the room door, but the PPE bin prevented the door from closing. The PPE bin was repositioned by RN J to allow for room [ROOM NUMBER] door closure. On 7/8/2020 at 10:16 a.m., the Resident from room [ROOM NUMBER] (room next to COVID-19 positive Resident #10) was observed self-propelling in her wheelchair on the 500 hall without a facemask. No staff member directed or offered facemask protection to this Resident. During an interview on 7/8/2020 at 11:00 a.m., Acting Director of Nursing (DON)/RN)/Infection Preventionist reported the facility had adequate supplies of PPE, and stated, (From) .the beginning, we have never been short of PPE. When asked about the use of N95 masks with exhalation valves, the acting DON stated, I am not really familiar with those, but confirmed surgical masks should not be worn underneath an N95 mask because it would not allow a proper seal of the N95 mask on the face. Regarding Resident #10's room door observed open, the acting DON stated, room [ROOM NUMBER] is on airborne precautions. The door should remain closed at all times .All residents in the hallways are to wear masks. The acting DON also confirmed the following expectations of care: 1. Quarantine residents would only leave their rooms wearing an N95 mask. 2. Used dinnerware would be disposed of in the resident room in their normal garbage, not brought out into the hallway. 3. Gloves would be worn by staff disposing of dirty dinnerware. Touching potentially contaminated dinnerware from quarantine rooms (with bare hands without hand hygiene) was not acceptable practice. On 7/8/2020 at 12:40 p.m., observation of airborne precaution rooms with the acting DON, found the following room doors open: #204, #303, and #404. On 7/8/2020 at 12:40 p.m. and 12:56 p.m., Respiratory Therapist (RT) M was observed, by this Surveyor and the Acting DON, at the nurses station with her face mask off/pulled down, not covering her nose or mouth on two separate occasions. RT M was instructed, by the Acting DON, to wear her facemask following the 12:56 p.m. observation On 7/9/2020 at 10:45 a.m., Temporary Nurse Aide - PCA Q was observed by this Surveyor and the Acting DON at the nurse's station, with her facemask hanging from her left ear, not covering her nose or mouth. PCA Q was drinking from a straw in a white Styrofoam cup. During an interview at this same time, the Acting DON stated, I expect (staff to wear) mask and goggles - you wear them. At the nursing stations they wear that (facemask and goggles) all the time. They shouldn't be eating or drinking at the nurse's station. On 7/10/2020 at 9:53 a.m., a telephone interview was conducted with (Name Brand) Technical Assistance EE regarding the 8511 N95 facemask with exhalation valve. Technical Assistance EE stated, It (8511 facemask) is designed to protect the wearer . it is not recommended if (staff are) sick. Technical Assistance EE provided via email a Technical Assistance Bulletin regarding the 8511 facemasks. Review of the (Brand Name) Technical Assistance Bulletin, dated 6/20, revealed the following: Be sure to select a respirator that can seal against your face without any gaps. To provide respiratory protection, a respirator must fit snugly on the users face to ensure there are no gaps between the face and the respirator seal. Even very small gaps between the face and the edge of the respirator allow air, and particles, to go around the filter media .respirators are designed to help reduce the wearer's exposure to airborne particles . The purpose of a respirator's exhalation valve is to reduce the breathing resistance during exhalation .The valve is designed to open during exhalation to allow exhaled air to exit the respirator and then close tightly during inhalation .there is a possibility that exhaled particles may leave the respirator via the valve and enter the surrounding environment . Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, update 4/13/2020, revealed the following, in part: .Place patients with suspected or confirmed COVID-19 in private rooms with the door closed . On 7/10/2020 at 9:00 a.m., during a telephone interview, Assistant Administrator (Staff) Z confirmed 67 staff members tested for COVID-19 during the first week of July had not received confirmation of their results as of this time. On 7/9/2020 at 11:30 a.m., following discussion of the above infection control concerns, the Nursing Home Administrator (NHA) acknowledged the above infection control concerns and stated, We will correct the issues and move forward.