STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235400	A. BUILDING _____ B. WING _____	04/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WELLSPRING LUTHERAN SERVICES	1390 MAPLE DRIVE FAIRVIEW, MI 48621

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** - Some	**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 during a COVID-Infection Control Survey. The facility failed to ensure consistent compliance with facility-wide systems for the prevention, identification, and/or control of infection of residents pertaining to appropriate use of Personal Protective Equipment (PPE). This deficient practice resulted in the potential for staff not wearing the correct PPE and/or wearing PPE incorrectly, increasing the risk of infections which could impact all of the residents in the facility. Findings include: On 04/14/20 at 9:46 a.m., the door to Resident #101's room (room [ROOM NUMBER]) was observed to be closed with a door hanger holding PPE, including gowns, gloves, and red biohazard garbage bags. A contact isolation sign was observed on the door of the room next to Resident #101's room; the room marked with the isolation sign was vacant. Housekeeper /Staff F was in the hallway preparing to clean the room and was asked what the protocol was for cleaning Resident #101's room. Staff F did not know and reported they would have to check with their supervisor. On 04/14/20 at 9:50 a.m., the following observations were made in Resident #101's room: A garbage can containing a red biohazard garbage bag with uncontained contact isolation gowns on the outside of the can. The bed had been stripped of the linen; A clear garbage bag containing soiled linen was on the floor. A plastic glass containing approximately one third of a clear liquid on the over the bed table. A blood pressure cuff, stethoscope, and pulse oximetry monitor (a device used to measure oxygen levels in individuals) was on the shelf in the room. On 04/14/20 at 10:25 a.m., Licensed Practical Nurse (LPN) I observed Resident #101's room with this Surveyor. LPN I did not believe Resident #101 had been in contact precautions prior to being transferred to the hospital. LPN I was asked why the PPE for contact precautions had been placed on the door and used contact gowns were in the garbage can. LPN I replied it was confusing and they weren't sure why the contact gowns had been placed on the door and used in the room. LPN I was not sure why the room had not yet been cleaned. On 04/14/20 10:30 a.m., Staff F and housekeeper (Staff G) were observed in Resident #101's room preparing to clean it Staff F and Staff G were unable to describe what type of PPE should be worn in Resident #101's room, and they were unsure if Resident #101 had been on contact precautions. Staff F and Staff Gstated their understanding was that wearing a gown was not needed in contact isolation rooms when the resident was not present. At this time Staff G's face mask was observed to have a bend in it which prevented it from being directly against their face. This Surveyor was able to visualize openings on both sides of the mask. On 04/14/20 at 10:44 a.m., Housekeeping/laundry Supervisor /Staff H was asked what the expectations were for cleaning of contact precaution rooms. Staff H replied the expectation would be for staff to wear the appropriate PPE for the type of precautions the resident had been on. Staff H stated Resident #101's room was to be treated like a contact precaution room and staff should have been wearing contact gowns. Staff H reported for contact rooms, there should be a laundry barrel with a yellow plastic bag to place the linen in. Staff H was aware Resident #101 had been transferred out on Sunday (April 12, 2020) but was not able to determine why the room had not been cleaned sooner. Staff H admitted it should have been cleaned yesterday (Monday, April 13, 2020). On 04/14/20 at 11:27 a.m., Staff G was asked why gowns were not needed to be worn when cleaning resident rooms if the resident was not present. Staff G confirmed that since the resident was not present in the room coughing, a gown did not need to be worn. Staff G was asked if they thought the resident may have touched surfaces and if germs may remain in the room after the resident was gone. Staff G replied when they thought about it that way, they could see why they should wear a gown. Staff G's mask was observed to have a fold in it and did not rest directly on their face. Staff G reported they had not received training on how to apply their face mask. On 04/14/20 at 12:54 p.m., via a telephone interview, LPN J reported they had taken care of Resident #101 on Saturday, April 11, 2020. Resident #101 had been doing well until evening and then had became pale, short of breath and had developed a fever of 99.1. LPN J notified the medical provider on call and had recieved orders for a chest x-ray and labwork. LPN J left at 6:00 p.m. that day. LPN J reported when they came to work on Sunday (April 12), Resident #101's room had PPE on the door and LPN J believed Resident #101 had been placed on contact precautions. LPN J reported wearing a contact gown when going into Resident #101's room until Resident #101 had been transferred out to the hospital on Sunday afternoon. LPN J could not recall whether or not a contact precaution sign had been posted on Resident #101's room. A review of Resident #101's Electromic Medical Record revealed a progress note written by LPN J on 04/11/20 at 17:20 (5:20 p.m.) which contained the following information: Resident up to w/c (wheelchair). Noted pale and SOB (short of breath). VS (vital signs): 180/80 - HR 120, Respers (respiratory rate) 28, Temp=99.1. O2 sat (oxygen saturation level) on RA (room air)=84% . Placed on O2 @ 2 lpm (oxygen at 2 liters per minute). call placed to on call (Nurse Practioner L) Orders to obtain PCXR (portable chest x-ray), CBC (a blood draw to determine a complete blood count), CMP (a blood draw to determine complete metabolic profile). On 04/14//20 at 1:02 p.m., RN K reported being the nurse manager on call over the weekend of April 11-12th and had received a telephone call from the night nurse regarding Resident #101's condition. RN K reported being notified that Resident #101 had a temperature of 99.0 and had experienced shortness of breath. RN K instructed the night nurse to move Resident #101 into room [ROOM NUMBER] and to hang PPE on the door. During an interview with the Infection Preventionist/RN E on 04/14/20 at 2:06 p.m., RN E reported Resident #101 did not have symptoms that would have warranted contact precautions. RN E stated whenever a resident was placed in contact precautions, the policy was to place a contact precaution sign on the resident's door which would provide information pertaining to what type of PPE was required. When asked if all staff had received training on PPE use along with the correct way to apply masks, RN E reported the entire facility had been educated but it had been a couple of months ago. RN E confirmed Resident #101 had been added to the April line listing for infection monitoring and tracking purposes. On 04//14/20 at 3:05 p.m., The Nursing Home Administrator (NHA), the Director of Nursing (DON), and RN E voiced concerns regarding the housekeeping findings regarding PPE. The DON acknowledged the lack of clarity with the housekeeping staff and manager regarding cleaning procedures on the newly designated isolation unit in discerning the difference between COVID-19 and isolation rooms. The DON reported they had educated Staff Gon proper mask usage the day before (April 13). A review of the Protective Attire Techniques policy with the release date of January 2010 revealed the following information, .Mask Techniques 2. Put mask snuggly over nose and mouth . A review of the facility policies Transmission Precautions: Contact and Transmission Precautions: Droplet, both dated April 2013, contained no information pertaining to contact precaution sign usage to provide information on what type of PPE to wear.

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