STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235267	A. BUILDING _____ B. WING _____	08/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE NURSING AND REHABILITATION CENTER	1225 WOODWARD AVENUE KINGSFORD, MI 49801

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 maintain infection control practices during a COVID-19 Focused Infection Control Survey. This deficient practice resulted in the potential for transmission of COVID-19 and other communicable diseases which had the potential to affect all 79 residents residing in the facility. This deficient practice has six noted deficiencies: 1. Failed to provide visible isolation signage for COVID-19 positive resident (Resident #1). 2. Failed to properly separate clean/dirty with regards to Personal Protective Equipment (PPE) supplies to prevent cross-contamination. 3. Failure to perform adequate COVID-19 visitor entrance screening. 4. Failed to properly clean/disinfect a thermometer used for COVID-19 screening 5. Failure to perform hand hygiene prior to medication administration (Resident #4), with feeding assistance (Resident #5, #6, and #7), and a transfer (Resident #9). 6. Failure to complete timely infection control surveillance and infection mapping for August 2020. (All times are Eastern Time Zone) Findings include: During an entrance interview on 8/7/2020 at approximately 8:50 a.m., Registered Nurse (RN) B identified the Director of Nursing (DON) as the Infection Preventionist with the back-up Infection Preventionist (due to her absence) as RN A. When asked about any COVID-19 positive lab results, RN B identified Resident #1 had a positive result and identified two other Residents (#2 and #3) were in 14-Day Quarantine Isolation for admission/readmissions. When asked about their room placements, RN B provided a facility map which allowed for a visual reference: Resident #1 was located on the lower level on the East Wing in room [ROOM NUMBER] at the far end of the hallway next to an exterior exit. Resident #2 was also on the lower level on the South Wing in room [ROOM NUMBER] along with Resident #3 located in room [ROOM NUMBER]. When asked what type of isolation precautions were in place for residents with actual/suspect COVID-19 infection, RN B responded, Airborne. When asked if the rooms were negative pressure, RN B said no but indicated full PPE was used which included: face shield, N95 (high filtration) mask, gown, and gloves. RN B stated both gowns and N95 masks were reused by staff throughout their shift. Deficient Practice One and Two: During an observation on 8/7/2020 at approximately 10:30 a.m., Resident #1's (COVID-19 lab confirmed positive) room door was found closed without the placement of any isolation signage to indicate isolation precautions were in place. There was no isolation cart/container with necessary PPE supplies located outside Resident #1's door. This Surveyor then entered the adjacent resident room (121) which found both clean PPE (unused) supplies were in direct, close proximity to soiled (used) PPE, without any clear separation for clean/dirty, which posed a risk for cross-contamination of COVID-19 and/or other organisms. Previously used isolation gowns (one blue and one yellow) were hung from the wall on the right side of the room. The gowns directly touched an overbed table that contained a face shield (unable to determine if clean/used), an opened brown storage bag which contained a used N95 mask, and a small stack of unused, storage bags (clean). The perpendicular wall (next to the entrance door) contained four face shields which hung from the wall (unable to determine whether clean/used). Directly beneath the face shields hanging on the wall, an overbed table contained four opened brown storage bags with previously used N95 masks, a container of disposable cleaning and disinfecting wipes, a Styrofoam cup with a liquid, and a covered straw which was punctured through the lid. The same table contained a hand sanitizer pump and additional clean gowns. A three-drawer storage bin was located directly under a face shield and directly next to the same overbed table. Across from the wall with the face shields, a medicine cart and a supply cart were found. During an interview on 8/7/2020 at 11:00 a.m., when asked why Resident #1 (who was positive for COVID-19) did not have any isolation signage on the door, RN A responded, We don't have any. During a phone interview on 8/7/2020 at 3:05 p.m., the Nursing Home Administer (NHA) said staff were expected to enter Resident #1's room (122) through the adjoining room (121) by way of the shared bathroom. When asked where staff were donning (putting on) and later removing (doffing) PPE used for Resident #1, the NHA responded, It's all done within room [ROOM NUMBER]. The NHA confirmed face shields, N95 masks, and gowns were reused for Resident #1 and stored in the same location (room [ROOM NUMBER]) along with clean, unused PPE supplies and the medication and treatment cart without any clear separation of the shared space. The NHA said all the PPE and supplies were only used for Resident #1 and did not understand the concern. This Surveyor explained the risk for indirect cross-contamination could possibly occur with staff that had been in that room and touched surfaces or supplies. When asked why Resident #1 did not have any isolation signage, the NHA did not respond. Review of Resident #1's Electronic Medical Record-Nursing Notes documented no isolation was in place for 14 separate nursing assessments performed from 7/18/2020 to 8/8/2020 which read in part, Currently in Airborne Respiratory Isolation: No. Resident #1 was ordered to be in isolation since admission on 7/16/2020 and was identified with a positive COVID-19 result on 7/29/2020. Review of Centers for Disease Control and Prevention (CDC) Coronavirus Disease 2019 (COVID-19) Key Strategies to Prepare for COVID-19 in Long-term Care Facilites (LTCFs), 5/13/20, read in part, Deficient Practice Three: On 8/7/2020 at 10:30 a.m., Activity Assistant (Staff R) was observed entering the facility through an exterior door located on the Lower Level, West Wing and self-screened for temperature and completion of the screening questionnaire. Staff R was wearing goggles and a mask while holding an open soda can. In the presence of RN P, Staff R verified she had self-screened for entrance and was not scheduled to work on the Lower Level. During an interview on 8/7/2020 at 11:00 a.m., RN A was asked to explain how staff and visitors were screened for facility entrance. RN A said staff individually screened themselves from three possible locations and completed the log themselves. RN A indicated the logs were later picked up by Managers. When asked about limiting the multiple screening locations, RN A said staff enter from the closest location based on where staff have parked their vehicles. RN A indicated all staff (regardless of the location they entered the building) proceed to the Lower Level to access the time clock (where the Quarantine Unit was located). RN A was asked what PPE was required to enter the facility. RN A said a face shield and mask was required in patient-care areas. When asked if the Quarantine Wing (Lower Level) was divided by a barrier to limit possible staff exposure to those who were not working on the Quarantine Wing from other staff, RN A responded No, it's open. When asked about visitor screenings, RN A indicated staff performed temperature and screening questionnaires at the front entrance. Review of multiple screening logs (July and August 2020) titled, Visitor Screening Temperature and Signs/Symptoms Log showed multiple entries without an entry dates, without resident's name (if applicable) for intended visit, without the completion of screening questions, and without recorded temperatures. Review of multiple screening logs (August 2020) titled, Focused Employee Temperature and Signs/Symptoms Log reflected several entries without staff work locations and two staff entries (Staff T and Staff Q) had indications of possible COVID-19 symptoms: headaches, congestion/runny nose, and nausea/vomiting who had worked their shifts. Review and comparison to facility provided, August 2020 Employee Illness Log showed neither Staff T not Staff Q had been identified nor tracked. Two unsuccessful telephone interview attempts were made on 8/11/20 at 3:47 p.m. and 3:56 p.m. for Staff Q and Staff T. During an interview on 8/7/2020 at 10:37 a.m., Physical Therapy Director (Staff) S was asked to explain staff screening process. Staff S said she collected the staff screening logs once she came into work around 8:45 a.m When asked if her staff began working with residents prior to her coming into work, Staff S responded, Yes, most of my staff begin before me by 8:30 a.m. and indicated one staff began work at 9 a.m. When asked what was done after collecting the logs, Staff S said she verified which staff were present and working with their schedules. During a telephone interview on 8/12/2020 at 7:58

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) a.m., Dietary Manager (DM) J was asked about the vendors screening process (COVID-19). DM J explained two separate screening forms were completed and one temperature was obtained on entrance to the facility. After comparison of the two forms (Coronavirus Disease 2019 (COVID-19) Visitor Screening and Visitor Screening Temperature and Signs/Symptoms Log), DM J was asked about multiple vendor entries (six total on the 7/3/20 log) that did not have the date of each vendor entrance and there were missing individual Coronavirus Disease 2019 Visitor Screening forms. DM J responded, I don't know why there's missing dates. Discussion ensued regarding the ability to accurately perform contact tracing with vendors if there was a COVID-19 exposure. Staff J responded, I understand what you're saying. When asked if the logs/forms were reviewed daily by Infection Control, DM J indicated the forms were submitted to the DON only when the forms were full. During a telephone interview on 8/12/2020 at 9:30 a.m., RN P was asked about the staff screening logs (COVID-19). RN P explained the logs were collected by nursing from the previous day (night shift) and from the morning shift and that they were placed in a binder for the DON. When asked about the afternoon logs, RN P explained RN B collected them and placed them in a binder for the DON. During a telephone interview on 8/12/2020 at 9:36 p.m., this Surveyor discussed the facility's current staff screening process (COVID-19) with having multiple logs, entry omissions, multiple screening locations, self-screening by staff, staff competencies with thermometer use, need for timely log reviews for possible concerns, when the NHA stated, I get it. Review of Centers for Disease Control and Prevention (CDC) Coronavirus Disease 2019 (COVID-19) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Diease 2019 (COVID-19) Pandemic Infection Control Guidance Updated 7/15/2020, read in part, Limit and monitor points of entry to the facility. Consider establishing screening stations outside the facility to screen individuals before they enter. Review of Centers for Disease Control and Prevention (CDC) Coronavirus Disease 2019 (COVID-19) Key Strategies to Prepare for COVID-19 in Long-term Care Facilites (LTCFs), 5/13/20, read in part, Actively screen anyone entering the building (HCP {Healthcare Personnel}, ancillary staff, vendors, consultants) for fever and symptoms of COVID-19 before starting each shift; send ill personnel home. Deficient Practice Four: During an observation on 8/7/2020 at approximately 10:20 a.m , on Lower Level (West Wing), an overbed table was found at the end of the hallway near an exterior door. A Focused Employee Temperature and Signs/Symptoms Log was found on a clipboard with a red colored pen and a box of 2 inch by 2 inch alcohol wipes. A (brand name) temporal thermometer was observed with a dirty (soiled) strip of surgical tape placed over the battery case which extended from the back around towards the front where the thermometer would be held for use. On 8/7/2020 at approximately 10:25 a.m., RN L, in the presence of RN B were shown the visibly soiled thermometer and were asked if the thermometer was clean and had a cleanable surface with the use of surgical tape. RN B, responded, No, it's not cleanable with the tape. Deficient Practice Five: During an observation on 8/7/2020 at 9:08 a.m., this Surveyor was positioned by East Wing's unattended, unlocked medication cart. When Registered Nurse (RN) D was asked about the unsecured medication cart with Resident #4's ten medication cards left on top, RN D proceeded to lock the medication cart, then touched her keyboard screen, and then handled the medication cards with bare hands. RN D stated, I was called into 230 (room). I definitely should have locked it up. RN D then proceeded to prepare Resident #4's medications without the performance of hand hygiene. During a dining observation on 8/7/2020 at approximately 9:13 a.m., Certified Nurse Aide (CNA) E simultaneously provided feeding assistance to Resident #5, Resident #6, and Resident #7 without consistent hand hygiene in-between. Resident #5 was seated in the hallway and Resident #6 and Resident #7 were in room [ROOM NUMBER]. CNA E handled Resident #5's milk cup and then abruptly left to enter Resident #6's and Resident #7's room. No hand hygiene was observed prior to his return to assist Resident #5. CNA E then proceeded to feed Resident #5 yogurt with a spoon. CNA E then again, left to enter Resident #6 and #7's room. When asked about feeding multiple residents simultaneously, CNA E stated, Someone called in and I need help. CNA E acknowledged providing feeding assistance in room [ROOM NUMBER] to both Resident #6 and #7. Hand hygiene (from the room's wall dispenser) was only observed one time immediately after this Surveyor requested an interview as CNA E was exiting room [ROOM NUMBER]. During a transfer observation on 8/7/2020 at approximately 9:30 a.m., CNA F removed the battery pack (with bare hands) from a transfer device for Resident #9 on the West Wing. CNA F vocalized the need to change out the battery and then left Resident #9's room and entered West Wing's Linen Room. No hand hygiene observed. CNA F returned to Resident #9's room and placed the battery pack into the transfer device. Next, CNA F adjusted Resident #9 clothes (upper left torso) and body, sling straps with bare hands without the performance of hand hygiene. CNA H arrived and performed hand hygiene prior to putting on clean gloves. CNA F touched Resident #9's body, the transfer device, and bed with bare hands and no hand hygiene performed prior to Resident #9's transfer back to bed with the assistance of CNA H. Observation of the West Wing hallway showed no hand hygiene dispensers mounted to the walls nor freestanding stations. Review of facility's Hand Hygiene policy/procedure (updated 3/2020) read in part, When to wash or use alcohol-based hand rub: After having direct contact with patient's intact skin .After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. Review of Centers for Disease Control and Prevention (CDC) Coronavirus Disease 2019 (COVID-19) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Diease 2019 (COVID-19) Pandemic Infection Control Guidance Updated 7/15/2020, read in part, Take steps to ensure that eveyone adheres to source control measures and hand hygiene practices while in a healthcare facility. Deficient Practice Six: During an interview on 8/7/2020 at 11:00 a.m., RN A confirmed the DON was currently on leave for a week since the beginning of August and RN A was the back-up Infection Preventionist. When asked to provide August 2020 resident infection control surveillance data (line-listing and mapping), RN A looked through several white, three ringed binders and located July 2020 data. RN A stated he was calling the DON to see if the requested data was located elsewhere. Upon RN A's return to continue the interview, he indicated that July 2020 was the latest surveillance data for resident infections and mapping. When RN A was asked why August 2020 resident surveillance log and mapping had not been completed in real time, RN A indicated he was unable since he had been working on the floor caring for residents. During a phone interview on 8/12/2020 at 9:36 a.m., the DON, in the presence of the NHA, stated she had completed August 2020 resident infection control surveillance to date upon her return from leave on 8/11/2020.