STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235664	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAMBRIDGE SOUTH HEALTHCARE CTR	18200 W 13 MILE ROAD BEVERLY HILLS, MI 48025

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 -** Immediate jeopardy **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, which is an identified hub for placement of COVID positive residents from the community, failed to institute and operationalize appropriate infection control principles and practices per the Centers for Disease Control Prevention (CDC) safety measures to prevent the exposure/transmission of residents to 2019 Novel Coronavirus (COVID-19) for: 1) three residents (R#s 711, 713 and 715) that were reviewed for cohorting (sharing a room) and/or being potentially exposed (R# 713) with COVID-19 positive residents (R#'s 710, 712, 714, and 716); 2) implementing CDC guidance on the discontinuation of precautions for positive COVID-19 residents (R#'s 710, 712, 714 and 716); 3) ensuring staff utilized the recommended Personal Protective Equipment (PPE) per CDC guidance during the recommended monitoring phase; and 4) implement CDC guidance on implementing precautions on residents that were readmitted (R#'s 717, 718 and 719). The failure to follow current CDC recommendations for COVID-19 resulted in an Immediate Jeopardy (IJ) to the health and safety of all residents, many of whom were at high risk due to age and co-morbidities, to be exposed and/or develop COVID-19, given the high risk of spread once COVID-19 enters a nursing home, facilities must take immediate action to protect residents, families, and healthcare personnel (HCP) from resulting in the likelihood of serious health complications from COVID-19 hospitalization s, and death. Findings include: The IJ began on 7/11/20. The IJ was identified on 7/29/20. The Administrator was notified of the IJ on 7/29/20 at 2:47 PM and a plan to remove the immediacy was requested. Although the IJ was removed on 7/30/20, the facility remained out of compliance at a scope of widespread and a severity of potential for more than minimal harm that is not Immediate Jeopardy due to sustained compliance that has not been verified by the State Agency. Resident #710 and Resident #711: R#710 A review into the clinical record revealed the following: R#710 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A COVID-19 Test Result Summary dated as reported to the facility on [DATE] documented a positive test result for R#710. CDC guidance for COVID-19 in the nursing homes documented in part, .If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit . The facility's census report revealed R#'s 710 and 711 shared a room until 7/13/20 (despite R# 710 testing positive for COVID- 19 on 7/11/20.) R#710 was moved onto the COVID unit on 7/13/20. A COVID-19 Test Result Summary dated as reported to the facility on [DATE] documented a negative test result for R#710. Further review of the census report revealed R# 710 was moved back into a shared room with R#711 on 7/19/20 (6 days after being transferred to the COVID-19 unit). A facility's COVID-19 protocol/guidance form (dated July 1, 2020) documented in part .Residents with laboratory-confirmed COVID-19 who have not had any symptoms (Asymptomatic) should remain in Transmission-Based Precautions until either: Time-based strategy - 10 days have passed since the date of their first positive COVID-19 diagnostic test, assuming they have not subsequently developed symptoms since their positive test .Test-based strategy Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of [DIAGNOSES REDACTED]-CoV-2 RNA from at least two consecutive respiratory specimens collected (more than or equal to) 24 hours apart (total of two negative specimens) . On 7/28/20 at 2:25 PM, a request to the Administrator was made for any further COVID test results for R#710 after the dates of 7/17/20 and no further results were provided by the end of survey. A physician order [REDACTED].Droplet precautions, every day and night shift for COVID Positive .Discontinued on 7/21/20 . Despite R#710 being put back into the room with R#711 on 7/19/20 (before the recommended time frame), which potentially exposed R#711 for a second time. R#711 A review into the clinical record revealed the following: R#711 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A COVID-19 Test Result Summary dated as reported to the facility on [DATE] documented a negative test result for R#711. However, R#711 remained sharing a room with their COVID positive roommate until 7/13/20. Further review of the physician orders, care plans and progress notes in the clinical record revealed R#711 was not considered as exposed or potentially infected. CDC guidance for COVID-19 in the nursing homes documented in part .Roommates of residents with COVID-19 should be considered exposed and potentially infected .HCP (Health Care Providers) should use all recommended COVID-19 PPE for the care of all residents on affected units .this includes both symptomatic and asymptomatic residents . This allowed staff to provide care to R#711 without the recommended PPE per CDC guidance, while providing care for other non-exposed residents on that unit. A facility's COVID-19 protocol (dated July 15, 2020) documented in part, . As of May 14, full PPE is recommended in the following areas: Admission units, Observations units . On 7/28/20 at 3:40 PM, the Director of Nursing (DON) who also serves as the facility's Infection Control Nurse (ICN) was queried on why R#710 was not initially moved out of the room with R#711 on 7/11/20 and moved onto the COVID-19 unit and stated in part .We didn't get the report until 7/13/20 . When asked why precautions weren't ordered for R#711 after having been in a room for two days with their COVID-19 positive roommate, the DON stated in part .We didn't put her on precautions because she was in a room by herself and asymptomatic and COVID-19 test was negative .She was on Enhanced Precautions . The DON was then asked to clarify the Enhanced Precautions and stated It's a mask for staff. Either a N95 or K95, we have the real masks here . An observation of a signage on the facility's wall documented Enhanced Droplet - Contact precautions which directed the staff to perform hand hygiene, utilize a N95/surgical face mask, eye protection, gown, gloves and guidance for a private room and keep door closed. Resident #717, Resident #718 and Resident #719: R#717 On 7/29/20 at 10:29 am, an observation was made of R# 717's room door. There was no signage posted to direct staff on what PPE to don on, nor was there PPE (gloves, gown, eye protection etc) located on or near the door. On 7/29/20 at 10:37 am, Licensed Practical Nurse (LPN) C (the nurse providing care for R#717) was queried regarding R#717 and if there was any further PPE required for HCP other than a mask and stated in part, .No, she isn't on precautions. We just wear a mask . A review of the clinical record revealed the following: R#717 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The residents census report revealed R#717 room placement as the following: 7/23/20 admitted into a private room; 7/26/20 moved into a room with R#'s 718 & 719; 7/27/20 moved into a private room; 7/28/20 moved back into a room with R#'s 718 & 719; 7/29/20 moved back to a private room; CDC's COVID-19 guidance for nursing homes document in part, .a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE . A facility's COVID-19 protocol/guidance form (no date) documented in part, .Re-Admissions .Residents who return with symptoms that test negative will remain in isolation on our admission unit for 14 days and will be monitored closely using droplet precautions outlined in our toolkits. Residents will be tested at Day 12 of their stay. Based on negative Day 12 test results, improvement or resolution of symptoms, and completion of 14 days of isolation, these residents can be moved off of isolation and droplet precautions to the broader resident population . After being readmitted , R#717 was moved out of a private room and into a room with R#718 and R#719 (potentially exposing these residents) and again on 7/28/20 (a potential second exposure). A review of R#717's physician orders, progress notes and care plans revealed no orders/interventions for precautions since being readmitted back into the facility on [DATE]. Which could have potentially exposed all HCP caring for the resident upon readmission and all of the resident's that the HCP were providing

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
	235664	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAMBRIDGE SOUTH HEALTHCARE CTR	18200 W 13 MILE ROAD BEVERLY HILLS, MI 48025

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) care for. On 7/29/20 at 11:28 am, the DON was queried on why R#717 was moved out of a private room three days after admission and cohorted with roommates and replied Because she was tested and it was negative . When queried on the facility's policy and CDC guidance to monitor readmissions for 14 days, the DON repeated She was tested and it was negative . When asked why R#717 was placed back into a private room on 7/27, then on 7/28 placed back into the room with R#'s 718 and 719 and then back into isolation on 7/29 the DON replied Her wheelchair didn't fit into the three bedroom. On 7/28 because she had a shared bathroom with a male, so the resident was moved back in the three bedroom and again the wheelchair couldn't fit so we put her back into a private room . The DON was then queried on R#718 and R#719, being that they were exposed twice to a recently readmitted resident and if any precautions were placed on the residents for the HCP to follow and the DON replied The roommates weren't put on precautions and their was no additional PPE required, other than a mask . CDC guidance for COVID-19 in the nursing homes documented in part .Roommates of residents with COVID-19 should be considered exposed and potentially infected .HCP should use all recommended COVID-19 PPE for the care of all residents on affected units .this includes both symptomatic and asymptomatic residents . A facility's COVID-19 protocol (dated July 15, 2020) documented in part, .As of May 14, full PPE is recommended in the following areas: Admission units, Observations units . On 7/29/20 at 11:47 am, LPN C was queried regarding a signage that was posted outside of a resident's room (an observation room) that documented Enhanced Droplet - Contact Precautions and asked what PPE was required for the staff to don on prior to entering the room and the LPN C replied in part .He was just moved to this room .there are no precautions, just a mask. The DON was then queried on that residents precaution status and stated No, he is on precautions. The DON was then observed instructing the LPN C of the signage on the door and informing them that if the sign is on the outside of the door then that resident is on precautions. LPN C was then queried on if they donned on the correct PPE while providing AM care or medications and stated in part .I haven't went into his room yet .We are doing the morning medications now. Resident 712 and Resident 713 Review of the census record revealed R712 and R713 had shared a room beginning on 5/26/20. Review of the clinical record revealed R712 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the COVID-19 test results for R712 revealed a positive test with a collection date of 7/9/20 and a report date of 7/11/20. Review of the census record revealed R712 was moved to a room on the COVID positive unit on 7/13/20, two days after the report date on the positive test results. Review of the clinical record revealed R713 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the clinical record for R713 did not reveal an order for [REDACTED]. On 7/28/20 at 2:35 PM, an interview was conducted and the DON was queried about R713 not being placed on droplet precautions after R713's roommate, R712, tested positive for COVID-19. The DON explained that because the facility tested all residents and staff weekly, and since there were no visitors allowed in the facility, there was no way for R713 to have been exposed to the COVID-19 virus, so there was no need for droplet precautions. R707 Review of the census record revealed R707 was moved into the same room as R713 on 7/17/20, four days after R713's last date of exposure to R712 who had tested positive for COVID-19. Review of the clinical record revealed R707 was originally admitted into the facility on [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. On 7/29/20 at 10:26 AM, an interview was conducted and the DON was queried about R707 being moved into R713's room on 7/17/20. The DON explained R707 was in a different room, but did not get along with their roommate, so R707 was moved to R713's room as there was an empty bed. When asked about the results of the COVID-19 tests and the timing of the room changes for R712, R713 and R707, the DON explained the facility used the collected date (7/9/20) for their timing. The DON stated, I know the regs (CDC guidelines) say 10 days, but we use symptom management. When asked how test results were used to determine if a resident could be cohorted with another resident, the DON explained only one negative test result was needed to move a resident if the resident was staying in the facility, if the resident was leaving the facility, two negative tests were required. Resident 714, Resident 715 and Resident 716: A review of the census record revealed R714, R715 and R716 had shared the same room beginning on 6/12/20. R714 A review of the clinical record revealed R714 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of COVID-19 test results for R714 revealed a positive test with a collection date of 7/9/20 and a report date of 7/11/20. A review of the census record revealed R714 was moved to a room on the COVID positive unit on 7/13/20, two days after the report date of the positive test results. R714 was then moved to a designated observation room (off of the facility's COVID unit) on 7/17/20, and then moved back to the original room on 7/21/20. R715 A review of the clinical record revealed R715 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of COVID-19 test results for R715 revealed an error with the collection for the test dated 7/9/20 and a negative test with a collection date of 7/13/20 and a report date of 7/15/20. A review of the census record revealed R715 was moved to an observation room (with enhanced precautions) on 7/13/20, then moved back to the original room on 7/16/20. Upon return to the original room, R715 was no longer on enhanced precautions (only five days following being exposed to R714 and R716 that tested positive for COVID-19). R716 Review of the clinical record revealed R716 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of the COVID-19 test results for R716 revealed a positive test with a collection date of 7/9/20 and a report date of 7/11/20. Review of the census record revealed R716 was moved to a room on the COVID positive unit on 7/13/20, two days after the report date of the positive test results. R716 was then moved to a designated observation room (off the facility's COVID unit) on 7/17/20, and then moved back to the original room on 7/21/20. On 7/28/20 at 2:35 PM, the DON was asked to explain about the delay in transfer to a room on the facility's COVID unit once test results were reported as positive. The DON reported the facility had been having issues with obtaining lab results timely from the lab that was processing the COVID tests and reported the facility had not been aware of the positive results until 7/13/20, at that time the residents were moved. When asked about whether there had been any documentation of discussion with the lab regarding these concerns, the DON reported she would follow up. There was no documentation provided by the end of the survey. When asked why R714 and R716 had been taken off the COVID unit after only 5 days following positive COVID tests, then only observation with enhanced precautions for five days, then returned to original room which was shared with R715, the DON indicated all the residents COVID tests had come back negative and upon review with Medical Director and Epidemiologist, were given the okay to return. (The clinical records were reviewed and there was no documentation to reflect any discussion and/or clinical justification to reflect this decision.) Removal Plan: This Removal Plan in response to the findings of immediate jeopardy on July 29, 2020 @ 2:47 PM. The facility submits response to abate the findings of immediate jeopardy associated with the recent COVID IC Survey. The Facility was made aware by State Surveyor on July 29, 2020 @ 2:47 PM of their decision to cite a deficiency at the level of immediate jeopardy related to following: Failure to follow CDC (Center for Disease Control) recommendations for monitoring residents who are positive for COVID-19 related to cohorting, Discontinuation of precautions, Donning appropriate PPE for residents who have been exposed to COVID-19, Monitoring residents admitted and readmitted to the facility. Plan of removal as follows: On July 29, 2020 all current Residents have been assessed to assure COVID-19 positive residents are not cohorted with COVID-19 negative Residents. On July 29, 2020 any resident who was not recovered per the CDC (Center for Disease Control) recommendations will not be cohorted and they will be retested for COVID-19. On July 29, 2020 the facility reviewed current residents to ensure contact precautions for COVID-19 positive residents were removed per the CDC (Centers for Disease Control) recommendations. On July 29, 2020 the facility reviewed all current residents to ensure contact precautions are in place per CDC (Center for Disease Control) recommendations. On July 29, 2020 The District Director of Clinical Services has reviewed and re-educated the Administrator, Director of Nursing and Medical Director on the CDC (Center for Disease Control) recommendations related to the following: Admissions policy related to monitoring of residents admitted and readmitted to the facility, discontinuation of precautions for COVID-19 positive residents, not cohorting COVID-19 residents and non COVID-19 residents and wearing appropriate PPE for residents who have been potentially exposed to COVID-19.