STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235094	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAMARITAS SENIOR LIVING CADILLAC	460 PEARL ST CADILLAC, MI 49601

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 maintain infection control measures and surveillance during a focused COVID-19 Infection Control survey. This deficient practice resulted in the potential for spread of COVID-19 (Novel Coronavirus Infection) in two units (100 and 400) out of a total of four residential units in the facility. Findings include: On 7/10/20 at 10:35 a.m., an interview with Licensed Practical Nurse (LPN) B revealed she was responsible for caring for all of the residents within the 100 unit, including COVID-19 positive residents, quarantined residents, and non-quarantine residents. On 7/10/20 at 10:45 a.m., an interview with Certified Nurse Aide (CNA) C revealed the following: When asked who is responsible for the care of the COVID-19 positive Resident (#53), CNA C stated We both take care of her, but (CNA E) does mainly because he knows her well. On 7/10/20 at 11:10 a.m., CNA C was observed tending to needs for Resident #51 who, according to CNA C, was not under a 14 day quarantine. CNA C subsequently then moved to provide care for Resident #50 who, according to CNA C, was under a 14 day quarantine period for COVID-19 monitoring. On 7/10/20 at 11:15 a.m., CNA E was observed providing main transferring assistance to the bathroom for Resident #53 with CNA C. On 7/10/20 at 11:30 a.m., an interview with LPN B revealed the following: When asked why Resident #51 who was out of the 14 day COVID-19 quarantine was not allowed to visit with his wife, who also resided at the facility, LPN B stated, We are not allowing anyone (residents) to go from station to station. On 7/10/20 at 12:05 p.m., Resident room doors for 108, 112, and 114 were observed open. These Residents according to LPN B, CNA C and CNA E were currently on a COVID-19 monitoring 14 day quarantine. No eyewear was observed in use during multiple observations of staff entering and exiting resident rooms who were considered under 14-day quarantine identified by facility staff. On 7/10/20 at 12:10 p.m., CNA E was observed during three separate interactions with COVID-19 positive Resident #53. None of these interactions included the use of any type of eye wear. Resident #53 was observed to have mildly labored breathing as noted when Resident #53 was moving about their room and unit with a four-wheeled walker prior to entry of CNA E and this Surveyor. This Surveyor observed Resident #53 having continued heavy breathing. CNA E was observed within approximately three feet of Resident #53 for all three interactions without protective eye wear while heavy breathing from Resident #53 continued. Resident #53 was not asked and was not required to wear a mask while staff were in the room for these three interactions. During observation of the donning procedure for PPE (personal protective equipment), CNA E initially grabbed the isolation gown indicating it was his, and his N95 (specialized protective mask) respirator hanging on the wall in Resident #53's room. CNA E then began to put on the isolation gown inside out, contaminating the skin and clothing of CNA E. CNA E then recognized the isolation gown was being donned inside out and turned it around to don the isolation gown correctly. CNA E indicated the isolation gown and N95 mask being donned was being used for his entire shift to preserve PPE, and had already been in use for the day. CNA E was then observed doffing by removing his gloves and proceeded to wash his hands following the final interaction with Resident #53. CNA E then proceeded to remove the isolation gown and N95 Mask and returned it to the hooks located within Resident #53's room. CNA E then reached into his pocket and pulled out a basic surgical mask to put on while still in the COVID-19 unit. CNA E did not perform hand hygiene following removal of the isolation gown and N95 mask before acquiring the basic surgical mask from his pocket and placing it on his face. CNA E then began to manipulate the basic surgical mask with his hands to fit his face, and in doing so CNA E touched his unwashed fingers near and around his eyes, nose and mouth. The observations were reviewed with CNA E, who verbalized understanding regarding this Surveyor's concerns regarding the infection control breaches observed. Resident #53 A review of the Electronic Medical Record (EMR) for Resident #53 revealed admission to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #53 resided on the 100 unit during this survey. A review of a nurse's note dated 7/4/2020 at 6:26 a.m. revealed (Resident #53) was moved to isolation around (10:00 p.m.) last night after a positive COVID-19 test result. Nursing staff attended (Resident #53) and met her needs throughout the night. (Resident #53 was assessed by this RN (Registered Nurse) at 6:00 (a.m.). (Resident #53) was SOB on exertion, and complained of a headache. Her O2 (oxygen) saturation on RA (room air) was consistently between 88-90 (percent). BP (blood pressure) 142/76 on her L (left) arm, HR (heart rate) 76 bpm (beats per minute), 22br (breaths)/min.(minute) (physician) notified. A review of a nurse's note dated 7/5/2020 at 11:12 a.m. revealed (Resident #53) had elevated blood pressure this morning, PRN (as needed) [MEDICATION NAME] (blood pressure medication) 0.3 mg (milligram) was given this morning with Am (morning) meds (medications). Blood pressure recovered to 134/78. (Resident #53) stated she felt it was harder to breathe, Spo2 (oxygen saturation) 90 (percent) on RA, RR (respiratory rate) 22. This nurse advised aid (CNA) to place oxygen on (Resident #53) if she felt more comfortable to it on. Temp (temperature) 97.8, Afebrile (without fever). Sent update to (physician). A review of a nurse's note dated 7/5/2020 at 6:12 p.m. revealed a Chest X-ray was obtained. Results as follows : Small right lower lobe infiltrate (abnormal substance accumulation). The heart is normal in size. No acute osseous abnormality. CONCLUSION : Small right lower lob (sic) infiltrate. Cardiomegaly (enlarged heart). (Physician) notified. A review of a skilled evaluation dated 7/10/2020 at 10:09 revealed a .Cough present. Small amount of sputum. Sputum is thin. Sputum clear. Moist/loose non-productive cough noted. Cough with effective airway: Yes. Cough with retained secretions: No. Pain related to coughing: No. Currently on respiratory antibiotics: Yes. Actively prescribed [MEDICATION NAME] . Resident #52 A review of the EMR for Resident #52 revealed admission to the facility on [DATE] with [DIAGNOSES REDACTED]. There were no orders seen to address Resident #52's 14 day quarantine status following admission. On 7/14/20 at 1:25 p.m., during the exit conference an interview with the DON (Director of Nursing) revealed There is nothing on the doors of the residents to indicate who is on quarantine. The unit manager keeps track of that on a list, and keeps the CNA's informed. On 7/13/20 at 4:08 p.m., a Social Services Note revealed Resident (#52) has been notified that her COVID (-19) Test returned Negative Results . Resident #51 A review of the EMR revealed an admission to the facility on [DATE] with [DIAGNOSES REDACTED]. According to staff, Resident #51 was no longer on a 14 day quarantine. Resident #50 A review of the EMR for Resident #50 revealed admission to the facility on [DATE] with [DIAGNOSES REDACTED]. According to staff, Resident #50 was on 14 day quarantine. There was no evidence on the door and no orders in the EMR to indicate Resident #50 was on a 14 day quarantine. A review of the facility policy Novel Coronavirus Prevention and Response policy dated 3/10/20 revealed the following: Procedure when COVID-19 is suspected or confirmed . d. Limit the number of people who enter the resident's room. Maintain a log of all people who enter the room. Identify specific staff to provide care to resident, if possible . f. Implement standard, contact plus, and droplet precautions, plus eyewear. Wear gloves, gowns, goggles/face shields, and masks upon entering room and when caring for the resident . A review of the Centers for Disease Control (CDC) website (accessed 7/15/20 at 9:55 a.m.) https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html revealed the following: Identify space in the facility that could be dedicated to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19. Identify HCP (health care personnel) who will be assigned to work only on the COVID-19 care unit when it is in use . .Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown. Depending on the prevalence of COVID-19 in the

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 -** Some	(continued... from page 1) community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP (Health Care Professionals) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected . .Page last reviewed : June 25, 2020 On 7/10/20 at 9:50 a.m. an entrance conference was conducted with the Nursing Home Administrator (NHA). The NHA confirmed that there was one Resident (#53) who tested positive for COVID-19, with the positive results received on 7/3/20. Resident #53 was transferred to the facility's isolation unit on 7/3/20. The NHA also confirmed that one staff member (Registered Nurse (RN) F) also tested positive for COVID-19 with results received on 7/3/20. RN F was removed from the floor on 7/3/20. On 7/14/20 at 8:30 a.m., a review of the facility's Infection Control Tracking Map for July 2020 was reviewed by this Surveyor. It was noted that Resident #53 was marked on the July 2020 tracking map with a blue dot. On the facility Color Key it described that a blue dot indicated LRI (lower respiratory infection). Review of the facility Antimicrobial Administration Tracking form for July 2020 read, (Resident #53); type: LRI/pneu (pneumonia); nosocomial; date of onset 7/6 order 7/7; s/s (signs/symptoms) cxr (chest x-ray) and cough; order: [MEDICATION NAME] 750 mg (milligrams) po (by mouth) daily times 7 days There was no indication on the facility's line list that Resident #53 had tested positive for COVID-19 on 7/3/20. On 7/14/20 at 9:00 a.m., a review of the facility's Staff Illness Log for July 2020 was reviewed. It was noted that RN F was not marked on the Staff Illness Log for her [DIAGNOSES REDACTED]. On 7/14/20 at 11:50 a.m. a telephone interview was conducted with the NHA and Director of Nursing (DON). The DON confirmed that Resident #53 was not placed on the July 2020 line listing or tracking map for COVID-19 until today, 7/14/20. When asked why Resident #53 was not placed on either the line listing or tracking map, the DON stated, This was all new to us. On 7/14/20 at 1:20 p.m., a telephone interview was conducted with the NHA and DON. The DON confirmed that RN F was not listed on the Staff Illness Log for July 2020. When asked why, the DON stated, Because (RN F) did not call in. This is all new to us as a facility. When asked if RN F had any symptoms related to COVID-19, the DON stated, (RN F) had diarrhea shortly after the test came back positive, our Health Department did document that this was a symptom. The DON confirmed that she was acting as the Infection Control Preventionist for the facility.