STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235332	A. BUILDING _____ B. WING _____	05/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTLAND, A VILLA CENTER	36137 W WARREN WESTLAND, MI 48185

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 properly maintain infection control practices during a Covid-19 Infection Control Survey affecting all of the residents in the Covid-19 unit with the potential for the spread of infection and/or perpetuating existing infections. Findings include: On 05/01/20 at 8:53 AM, a tour of the facility's Covid-19 unit was conducted. The entrance area to the Covid-19 unit was monitored by a staff member that sat in front of a zippered curtain and a bedside stand stocked with Personal Protection Equipment (PPE) such as gloves, head coverings, plastic gowns, foot coverings , and hand sanitizer. Once inside the unit a spray bottle of disinfectant and two bins were observed, one labeled trash and the other bin was labeled soiled. On 05/01/20 at 9:00 AM, an interview with Nurse B was conducted. Nurse B was asked about the unit's staffing and stated, We have 48 residents, three nurses and five Certified Nurses Aides (CNAs). All of the residents on this unit have tested positive for Covid-19. It was observed that all of the resident's room doors were closed and there were signs describing what PPE to use posted on the resident's doors. On 05/01/20 at 9:06 AM, CNA Z was observed carrying two breakfast trays to a dietary cart and placed the trays into the cart. CNA Z was wearing a mask and a hospital style patient gown and no gloves. CNA Z then knocked on a resident's door, entered briefly and exited, no hand hygiene was observed. CNA Z then knocked on another resident's room door, entered and returned to the dietary cart and placed the tray in the cart, no hand hygiene was observed. CNA Z then moved a wheelchair from in front of the dietary cart and pulled the cart toward the entrance of the Covid-19 unit. On 05/01/20 at 9:15 AM, CNA Z was interviewed regarding PPE and stated we were in-serviced on how to put PPE on properly when we first started. CNA Z was asked about the hospital gown and having unprotected arms and stated, I'll take a shower right away when I get home. CNA Z was asked about the use of gloves when handling resident's trays and stated, That's where I'm confused. I'll find out. CNA Z then left the unit with the dietary cart. Upon return CNA Z was observed to still be wearing the hospital gown and no gloves, knocked on a resident's door and entered briefly and returned to the hall and pushed a small cart with clean linen down the hall. On 05/01/20 at 9:24 AM, CNA AA was observed exiting a resident's room with a breakfast tray, without wearing gloves. It was also observed that CNA Z was already in the room. CNA A then placed the tray in a cart and returned to the room and loudly stated, I'm going to wash my hands. CNA Z then went into the next room still in the hospital gown and without gloves. On 05/01/20 at 9:27 AM, CNA CC arrived with a breakfast tray, and entered the room that CNA Z had just entered, placed the tray, without gloves, on the resident's over-bed-table, adjusted the table and exited the room. CNA CC was observed to be wearing a cloth mask over a surgical mask. CNA CC was asked about the masks and stated, A (person) that works out there made them for us. CNA CC was then asked about wearing gloves when assisting residents and stated, You can wear gloves or you can wash your hands. CNA CC then went to the nurses medication cart and sanitized using Alcohol Based Hand Rub (ABHR). On 05/01/20 at 9:31 AM, CNA Z returned to the hallway and was asked about the last in-service on caring for Covid-19 residents and stated, I was off that day so I don't know what they taught. I just checked with my Administrator and was told we don't have to wear gloves to just pick up trays. On 05/01/20 at 9:35 AM, Nurse B was asked about what PPE the CNAs should be using while picking up trays and stated, They should be wearing gowns, gloves, masks, and they should be washing their hands before and after each resident. R907 On 05/01/20 at 9:38 AM, R907 was observed lying in bed with a face mask lying on the resident's over-bed-table. R907 was asked about the mask and stated, that's for when they (the staff) are in the room. R907 was asked about the care received and stated, I'm not the perfect (person) to answer that question. R907 was asked if the staff washed or sanitized their hands after assisting with care and stated, I haven't seen any of that. R907 was then asked if the staff assisted or offered assistance with hand washing or sanitizing the resident's hands before meals or after going to the bathroom and stated, You should know better than that, that would be too much like right. Record review of R907's Electronic Health Record (EHR) revealed that R907 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) assessment dated [DATE] revealed R907 had a Brief Interview for Mental Status (BIMS) score of 14 indicating an intact cognition and needed extensive assistance with Activities of Daily Living (ADLs) including hygiene. R908 On 05/01/20 at 9:43 AM, R908 was observed lying in bed watching TV and wearing a surgical mask. R908 was interviewed regarding the care received at the facility and stated, They do what they need to do. I won't tell lies. R908 was asked if the staff wash their hands after helping with ADLs and stated Yes. R908 was asked if the facility's staff assisted with hand washing or sanitization before eating or after using the bathroom and stated, I have not been helped with any of that. Record Review of R908's EHR revealed that R908 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS dated [DATE] revealed R908 had a BIMS score of 15 indicating an intact cognition and needed extensive assistance with ADLs including hygiene. R909 On 05/01/20 at 9:59 AM, R909 was observed lying in bed watching TV and wearing a surgical mask. R909 was interviewed regarding the care received and stated, Well, I go to [MEDICAL TREATMENT] early in the morning and I've only been here for one week. I was late for [MEDICAL TREATMENT] last time. R909 was asked if the staff washed or sanitized their hands after assisting with ADLs and stated, I can't see them in the bathroom because it's back there and (my roommate) keeps the curtains pulled. R909 was then asked if the staff assisted with hand hygiene before meals or after using the bathroom and stated, No, I have to ask for a washcloth and water. Record review of R909's EHR revealed R909 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS dated [DATE] revealed R909 had a BIMS of 15 indicating an intact cognition and needed extensive assistance with ADLs including hygiene. Record review of a copy of the signs posted on the resident's doors in the Covid-19 unit titled, PERSONAL PROTECTION EQUIPMENT (PPE) GUIDELINES with an illegible date of publication revealed that, Healthcare Personal Caring for COVID-19 patients-Suspected or confirmed .N-95 Respirator .Eye Protection .Gown .Gloves -Disposable gloves. -Remove and discard gloves when leaving the patient care area. On 05/01/20 at 10:33 AM, the Infection Control Preventionist ICP was interviewed regarding the facility's policy and procedure for PPE use by the facility's staff caring for residents in the Covid-19 unit and stated, We have on-going in-services and are following the guidelines of the CDC (Center for Disease Control). The ICP was then asked who monitored the staff for compliance with Infection Control guidelines and stated, I do, and if I see a problem I immediately in-service them. The ICP was asked why the nurses in the Covid-19 unit are not monitoring the CNAs and other staff for compliance with CDC guidelines regarding PPE use and offered no explanation. On 5/1/20 at 9:00 AM, Certified Nursing Assistant (CNA) O was observed on unit two of the facility wearing a mask covering their face. No other Personal Protection Equipment (PPE) was observed being worn by CNA O. CNA O was queried on what PPE they should be wearing and stated, I was given a bag with a mask in it. CNA O was queried on if they knew who to go to in order to obtain additional PPE. CNA O was unable to provide an answer. On 5/1/20 at 9:08 AM, an observation was made that all staff working on unit two were wearing full PPE which included, a mask, gloves, and a gown and/or raincoat. On 5/1/20 at 9:15 AM, Assistant Administrator (AA) Q was queried about PPE required for CNAs working on the units and CNA O wearing a

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) face mask and nothing else. AA Q stated, I will get her full PPE now, she just came back to work today. On 5/1/20 at 11:40 AM, Infection Control Preventionist (ICP) was queried on required PPE to be worn by staff while caring for residents at the facility. ICP stated, All staff should be wearing Center for Disease Control (CDC) approved PPE which includes, masks, gloves, gown, or raincoat to cover clothing. On 5/1/20, facility policy titled, Infection Prevention And Control Interim Guideline for Suspected or Confirmed [MEDICAL CONDITION] (COVID-19) dated 3.26.2020 and Revised: 4.6.2020 stated the following: Guideline Updated April 3, 2020 (CMS COVID-19 Long Term Care Facility Guidance April 2, 2020) Full PPE should be worn per CDC guidelines for the care of any resident with known or suspected COVID-19 .If COVID-19 transmission occurs in the facility, healthcare personnel should wear full PPE for the care of all residents irrespective of COVID-19 [DIAGNOSES REDACTED].