STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235519	A. BUILDING _____ B. WING _____	04/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KING NURSING & REHABILITATION COMMUNITY	2280 TOWER HILL RD HOUGHTON LAKE, MI 48629

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 for six Residents (#1, #2, #3, #4, #5, and #6) of six residents reviewed for infection control. This deficient practice resulted in the potential transmission of COVID-19 which had the ability to affect all 44 residents residing in the facility. Findings include: A review of the Electronic Medical Record (EMR) for Resident #1 revealed the resident was admitted on [DATE] with diagnoses, including: pneumonia, shortness of breath, and hypoxemia (low blood oxygen level). Further review of the EMR revealed Resident #1 had been placed in a contact isolation room upon admission. On 4/8/20 at 9:40 a.m., the Nursing Home Administrator (NHA) reported, Resident #1 had been transferred from a nearby hospital with testing results for COVID-19 negative. Further review of Resident #1's EMR revealed testing results, dated 3/31/20, confirmed Resident #1 had been tested for COVID-19 on 3/25/20 with negative results as of 3/31/20. A review of a History and Physical (H&P) report, dated and signed by Resident #1's attending physician, revealed the following, in part: Resident still in isolation due to recent illness and COVID exposure. On 4/8/20 at 11:38 a.m., a blood pressure cuff and stethoscope were observed in the contact isolation room, where Resident #1 resided. Licensed Practical Nurse (LPN) C reported the stethoscope and blood pressure cuff were dedicated to the contact room and remained in the room. When asked if there was a thermometer and oxygen saturation monitor present in the room, LPN C replied, They should be in here, I don't see them. During an interview with the NHA and the Infection Control Nurse/ Registered Nurse (RN) A on 4/8/20 at 12:48 p.m., when asked about the policy for vital sign equipment pertaining to contact isolation rooms, RN A reported the equipment should remain in the isolation room. The NHA confirmed the expectation was for equipment used in isolation precaution rooms, to be dedicated for use only in that room. The NHA revealed the facility did have an adequate supply of thermometers and oxygen saturation monitors to allow for the dedication of equipment to the contact isolation room. On 4/8/20 at 1:32 p.m., Certified Nurse Aide (CNA) B was asked what the process was for taking temperature and oxygen saturation monitors into contact isolation rooms. CNA B reported staff kept a thermometer and oxygen saturation monitor in their pocket. CNA B revealed staff carried the devices into the room for use on the residents and then pocketed the equipment to carry out of the contact isolation room after the resident's temperature and oxygen level were measured. CNA B verified there was not a dedicated thermometer or oxygen saturation monitor in the contact isolation room. A review of the policy titled, Isolation Categories of Transmission Based Precautions, revised 3/2018, revealed the following information, 5. When possible, dedicate the use of non-critical resident care equipment such as stethoscope, sphygmomanometer (blood pressure cuff), bedside commode, or electronic thermometer . Residents #3, #4, #5 and #6 An observation on 4/8/20 at 10:50 a.m., revealed CNA D placing an oxygen saturation monitor on Resident #2's finger. Upon obtaining the result, CNA D removed the device from the resident and exited the room. CNA D placed the device on a wheeled table in the hallway without cleaning or disinfecting the device. CNA D performed hand hygiene, proceeded to pick up the soiled oxygen saturation monitor from the wheeled table, then carried the device into Resident #3's room and placed it on the resident's finger. When finished, CNA D removed the device from Resident #3, walked to the hallway and placed the device upon the wheeled table without cleaning or disinfecting the device. Upon completing documentation, CNA D picked up the monitor, entered Resident #4's room, and placed the soiled monitor on the resident's finger. When finished, CNA D left the room and placed the device on the wheeled table in the hallway, without cleaning or disinfecting the device. CNA D performed hand hygiene then proceeded to pick up the soiled oxygen monitor, entered the room shared by Residents #5 and #6. The CNA proceeded to place the device on the finger of Resident #5. Upon obtaining a result from Resident #5, CNA D immediately approached Resident #6 and placed the oxygen monitor on the resident's finger. CNA D did not perform hand hygiene or disinfect the oxygen monitor after providing care to Resident #5 or prior to providing care to Resident #6. CNA D left the room, placed the oxygen monitor on the wheeled table without cleaning or disinfecting the device. CNA D was asked at that time what the procedure was for cleaning the oxygen monitor between residents. CNA D replied she should be cleaning the device, .but I'm new and I don't know where the supplies are, but yes, it (equipment) should be cleaned in between (resident contact). On 4/8/20 at 11:05, LPN C was asked what the procedure was for disinfecting equipment after use on a resident. LPN C reported facility policy was for all equipment to be cleaned after use on a resident, prior to use on another resident. On 4/8/20 at 11:10 a.m., RN A revealed the expectation was for staff to clean and disinfect all equipment after use on a resident, prior to use on any other resident. RN A also reported all staff were expected to perform hand hygiene after resident contact, prior to providing care to other residents. On 4/8/20 at 1:00 p.m., a review of the education provided to staff in response to the COVID-19 pandemic, revealed a form titled, Handwashing Audit, used to evaluate staff hand hygiene practices. Review of the audit for CNA D revealed the following, in part: Did the employee(s) wash hands with soap and water or use ABHR (alcohol-based hand rub) at appropriate times? NO . If the answer was no, provide on-the-spot education and re-audit the employee. Further review of the audits revealed no re-evaluation for CNA D. On 4/8/20 at 1:13 p.m., RN A was asked if CNA D had been re-evaluated for hand hygiene competency. RN A replied the Director of Nursing (DON) was responsible for completion of the audits but was currently out of the office. RN A left to check in the DON's office for additional completed forms. RN A returned to inform this Surveyor the DON had not completed the re-evaluation of CNA D. When asked if CNA D had been allowed to work without competency in hand hygiene, RN A replied CNA D had had worked on 4/7/20 and was currently working the day of the survey, 4/8/20. RN A stated the competency for CNA D would be completed immediately. A review of the policy titled, Hand Washing/Hand Hygiene, dated 4/2020, revealed the following, in part: Wash hands and other skin surfaces when: 3. After care of each resident. A review of the policy titled, 2019 Novel Coronavirus (COVID-19), revealed the following, in part: Precautions for COVID-19: Proper hand hygiene continues to be vitally important. A review of the policy titled, Isolation - Categories of Transmission Based Precautions, dated 3/2018, revealed if common equipment is used among more than one resident, .then adequately clean and disinfect . before use on another resident.

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.