STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235594	A. BUILDING _____ B. WING _____	09/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST WOODS OF NILES	**1211 STATE LINE RD NILES, MI 49120**

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 0773 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to obtain physician orders [REDACTED].#100, #102, #103, #104, #105, #106, #107, #108, #109, #112, #113, #114, #115, #116, #117, #118, #119, #121, and #122), reviewed for physician's orders [REDACTED]. Findings include: Health care provider- initiated interventions are dependent nursing interventions, or actions that require an order from a health care provider. The interventions are based on the health care provider's response to treating or managing a medical diagnosis .As a nurse you intervene by carrying out the health care provider's written and/ or verbal orders. Administering a medication, implementing an invasive procedure (e.g., inserting a Foley catheter, starting an intravenous (IV) infusion) and preparing a patient for diagnostic tests are examples of health care provider-initiated interventions. Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations -). Elsevier Health Sciences. Kindle Edition. Review of the facility's policy Specimen Testing for [DIAGNOSES REDACTED]-CoV-2, dated 4/2020, revealed .It is the policy of this facility to conduct [DIAGNOSES REDACTED]-CoV-2 testing in consultation with the Health Care Practitioner and /or Medical Director of this facility . Review of the Order Summary Report, on 9/2/20, for Residents #100, #102, #103, #104, #105, #106, #107, #108, #109, #112, #113, #114, #115, #116, #117, #118, #119, #121, and #122 revealed these residents did not have physician's orders [REDACTED]. Review of the Order Summary Report, on 9/2/20, revealed Residents #100, #102, #103, #104, #107, #108, #109, #112, #113, #114, #115, #116, #117, #118, #119, #121, and #122 had physician's orders [REDACTED]. The standing orders implemented on 9/2/20 were .COVID 19 Testing and/or Antibody testing per availability and CDC guidance .Active .9/2/20 . Review of Resident #100, #102, #103, #104, #105, #106, #107, #108, #109, #112, #113, #114, #115, #116, #117, #118, #119, #121, and #122's COVID 19 lab results, revealed these residents had multiple COVID 19 test performed ranging from 4 to 14 COVID 19 tests from 4/29/20 to 9/1/20. Review of the Order Summary Report, on 9/3/20, revealed Residents #105 and #106 did not have COVID 19 testing standing orders implemented. Review of Resident #105's Face Sheet revealed she was admitted on [DATE]. Review of Resident #106's Face Sheet revealed he was admitted on [DATE] and readmitted on [DATE]. In an interview on 9/3/20 at 2:00 PM, Director of Nursing B (DON) indicated on 9/2/20 the facility realized the long-term residents in the facility did not have COVID 19 individual test ordered or COVID 19 test standing orders. DON B indicated new admission or readmissions as of July had COVID 19 testing standing orders that were initiated upon admission. DON B indicated corporate produced standing order sets and corporate developed and implemented the COVID 19 standing orders in the beginning of July. DON B indicated all the residents admitted or readmitted prior to July do not have orders for any of their COVID 19 testing, from 4/29/20 to 9/1/20. DON B indicated almost all of our residents have had COVID 19 testing done multiple times.
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 follow standard precautions and Center for Disease Control (CDC) guidelines for hand hygiene, gloves use, protective personal equipment (PPE) use, sanitization of resident shared equipment, linen transportation, and social distances during a COVID 19 outbreak for 20 of 24 residents (Resident #109, #123, #122, #102, #101, #103, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #104, #105, and #106) reviewed for infection control, resulting in the potential for bacterial harborage and the spread of infectious diseases. Findings include: Review of the facility's Hand hygiene policy, revised 3/2020, revealed .Hands may be cleaned using liquid soap and water or alcohol based rub .Hands should be cleaned .before and after caring for different residents .After handling contaminated environmental objects . When hands are visibly soiled or potentially contaminated . (.following removal of gloves) . Review of the facility's Standard Precautions policy, last revised June 2020, revealed, .Person Protective Equipment (PPE): .Gloves .remove after use, perform hand hygiene before touching non contaminated items and surfaces, and before going to another patient . Facial Protection . Wear eye protection as recommended by the Center of Disease Contol (CDC) during outbreaks . Gowns . Remove soiled gown .and perform hand hygiene . Patient Care Equipment . Clean, disinfect, and reprocess reusable equipment appropriately before use with another patient . Review of the facility's Droplet Precautions policy, revised 8/2020, revealed .It is the policy of this facility to use category -specific isolation techniques for residents who have infectious or communicable diseases that may necessitate the use of barriers in addition of those used for Standard precautions. Droplet precautions will be used of residents known or suspected to have serious illnesses transmitted by large particle droplets . To control and limit potential outbreaks and clusters of infection caused by organisms spread by droplets in the air . infections spread by droplet transmission include . COVID 19 . ensure that resident are physically separated at least six feet from each other . Review of the Center for Disease Control (CDC)'s Coronavirus Disease Healthcare Workers Infection Control Guidance, revised last 7/15/20, revealed . Encouraging Physically Distancing . when possible, physical distancing (maintaining 6 feet between people) is an important strategy to prevent [DIAGNOSES REDACTED]-CoV-2 transmission . Designating areas . eat, and drink that allow them to remain at least 6 feet apart from each other, especially when they must be unmasked . Personal Protective Equipment .HCP (health care providers) who enter the room of a patient with suspected or confirmed [DIAGNOSES REDACTED]-COV-2 (COVID-19) infection should adhere to Standard Precautions and use a .N95 (mask), gown, gloves, and eye protection . perform hand hygiene before and after all patient contact .and before putting on and after removing PPE . https://cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html Review of the Linen Handling and Storage policy, dated 8/2020, revealed .Housekeeping and Laundry personnel should wear gloves, and other personal protective equipment as indicated when . handling, transporting .linen . Transporting Clean Linen .Clean linen must be wrapped or covered during transportation to avoid contamination .Distributing Clean Linen .Handle clean linen as little as possible . Resident #109 Review of the Face Sheet revealed Resident #109 was a [AGE] year-old female admitted to the facility on [DATE]. During an observation on 9/1/20 at 2:40 PM, Certified Nursing Assistant M (CNA) entered Resident #109's room, attended to the resident's care needs and exited. No hand hygiene was observed upon exit. CNA M entered the nurse's station used the phone. No hand hygiene was observed. Resident #123 Review of the Face Sheet revealed Resident #123 was an [AGE] year-old female admitted to the facility on [DATE]. During an observation on 9/1/20 at 2:45 PM, CNA M entered Resident #123's room. No hand hygiene was observed upon entry. CNA M wrapped a gait belt around Resident #123 and assisted her to the toilet. No hand hygiene observed. Resident #122 Review of the Face Sheet revealed Resident #122 was an [AGE] year-old female admitted to the facility on [DATE]. Resident #122 was on transmission-based droplet precautions. During an observation on 9/2/20 at 10:00 AM, Housekeeper T donned gloves, mask, and face shield and entered Resident #122's droplet precautions room. No gown was observed. Housekeeper T cleaned the floors and high touch resident items. Housekeeper T's body and clothing came in contact with the bed, bed covers, and bedside table. Resident #102 Review of the Face Sheet

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) revealed Resident #102 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #102 was on transmission-based droplet precautions. During an observation on 9/2/20 at 10:15 AM, Housekeeper T donned gloves, mask, and face shield and entered Resident #122's droplet precautions room. No gown was observed. Housekeeper T cleaned the floors and high touch resident items. Housekeeper T's body and clothing came in contact with the bed, bed covers, and bedside table. In an interview on 9/2/20 at 1:35 PM, Housekeeper T indicated staff did not need to wear a gown in an droplet precautions room if they were not providing patient care. Resident #101 Review of the Face Sheet revealed Resident #101 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #101 was on transmission-based droplet precautions During an observation on 9/1/20 at 12:30 PM, CNA H and Housekeeper G were in Resident #101's room. Resident #101 was seated in her wheelchair. CNA H was cleaning Resident #101's room wearing a gown, mask and face shield. No gloves were observed. Housekeeper G handled Resident #101's personal items and bed clothes while cleaning. CNA H was kneeling talking to Resident #101, touching her arm, clothing, and wheelchair. CNA H had the face shield flipped up, exposing CNA H's face. No gloves were observed. CNA H exited Resident #101's room and doffed gown and adjusted face shield over face . No hand hygiene was observed. Housekeeper G exited Resident #101's room and doffed gown. No hand hygiene was observed. Licensed Practical Nurse I (LPN) asked Housekeeper G for hand sanitizer (wall mounted hand was sanitizer empty), Housekeeper G handed a bottle of hand sanitizer from housekeeping cart to LPN I. Housekeeper G took the hand sanitizer back and did not use it. Housekeeper G donned a new gown and headed to the next room. No hand hygiene observed prior to donning gown. Resident #102 Review of the Face Sheet revealed Resident #102 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #102 was on transmission-based droplet precautions. During an observation on 9/1/20 at 12:40 PM, Housekeeper G entered Resident #102's droplet precautions room. Housekeeper G entered wearing a gown, mask, and face shield. No gloves were observed. Housekeeper G cleaned Resident #102's room, exited, and doffed gown. No hand hygiene observed. In an interview on 9/1/20 at 12:42 PM, Housekeeper G indicated did not wear gloves in Resident #101 or #102's room. Housekeeper G indicated typically wore gloves while cleaning with a wet rag but should wear gloves at all times while cleaning in resident rooms. Housekeeper G indicated did not perform hand hygiene before entering or after exiting Resident #101 or 102's room despite giving a bottle of hand sanitizer off the housekeeping cart to LPN I. Resident #103 Review of the Face Sheet revealed Resident #103 was a [AGE] year-old male admitted to the facility on [DATE]. Resident #103 was on transmission-based droplet precautions. During an observation on 9/1/20 at 12:45 PM CNA H exited Resident #101's room (no hand hygine performed) and in the hall walked past a functioning wall mounted hand sanitizer. No hand hygiene observed. CNA H continued walking and saw LPN I in the hallway attending to Resident #103 (in droplet precautions) kneeling on the ground in front of his wheelchair. CNA H went to LPN I and Resident #103 and assited LPN I in transferring Resident #101 into his wheelchair. CNA H obtained the vital signs cart and took Resident #103's vital signs. CNA H wiped the vital signs cart, blood pressure cuff, and pulse oximeter finger probe. The total cleaning time of all 3 items was approximately 30 seconds. Review of the MicroDot Bleach Wipes directions for use written on the outside of the wipes container found on the vital signs caddy used by CNA H, revealed .Apply towelette and wipe desired surface to be disinfected .A 30 second contact time is required to kill the bacteria [MEDICAL CONDITION] (Influenza [MEDICAL CONDITION], Human Immunodeficiency Virus, [MEDICAL CONDITION] Virus, and [MEDICAL CONDITION] Virus .) on the label except a 1 minute contact is required to kill [MEDICAL CONDITION][MEDICATION NAME] (yeast) and [MEDICATION NAME] interdigitale (fungal infection), and a 3 minute contact time is required to kill [MEDICAL CONDITION] spores .Reapply as necessary to ensure that the surface remains visibly wet for the entire contact time .Allow surface to air dry . In an interview on 9/1/20 at 12:55 PM, CNA H indicated had just removed gloves in Resident #101's room when Resident #101 asked a question. CNA H indicated knelt closer to communicate with Resident #101 and did not put gloves back on prior to touching Resident #101's chair, clothes, and arm. CNA H indicated did not perform hand hygiene after doffing gown and before helping Resident #103. CNA H indicated used Microdot Bleach Wipes to clean the vital signs machine, blood pressure cuff, and pulse oximeter finger probe after use with Resident #103. CNA H indicated did not know how long the machine must remain wet (contact time) to effectively sanitize the shared resident equipment (time was written boldly on wipe canister). CNA H asked LPN I if knew the contact time. CNA H indicated LPN I thought the contact time was 2 minutes, but they had not had any education on how long the equipment should be wiped or remain wet to effectively sanitized the shared resident equipment. CNA H indicated wiped the entire machine, blood pressure cuff, and pulse oximeter finger probe for approximately 30 seconds. Resident #110 Review of the Face Sheet revealed Resident #110 was a [AGE] year-old male admitted to the facility on [DATE]. During an observation on 9/1/20 at 3:00 PM, CNA X entered Resident #110's room with a vital sign cart. CNA X took Resident #110's vital signs and placed the vital signs cart in the hall. No sanitization of the vital signs cart, blood pressure cuff, or pulse oximeter finger probe was observed. Resident #111 Review of the Face Sheet revealed Resident #111 was a [AGE] year-old male admitted to the facility on [DATE]. Resident #111 was on transmission-based droplet precautions. During an observation on 9/1/20 at 3:05 PM, CNA X retrieved the vital signs caddy from the hall and entered Resident #111's droplet precautions room to take his vital signs. CNA X wiped the vital signs cart, blood pressure cuff, and oximeter in his room for approximately a total of 30 seconds. In an interview on 9/2/20 at 11:00 AM, Director of Nursing B (DON) indicted the facility does not have any COVID 19 positive residents. DON B indicted they do have several residents in droplet precaution for 14 days or more because they were newly admitted or had gone or go out of the facility for care. All staff should wear gown, gloves, mask, and face shield when entering these rooms, including housekeeping, laundry, dietary, and maintenance. DON B indicated resident shared equipment, like a vital signs cart, should be wiped down for at least 30 second, and in some cases longer, for example, [DIAGNOSES REDACTED] contact time is 3 minutes. DON B indicated preferred each part of the machine remained wet for 3 minutes prior to use but if not possible each part of the vital signs caddy should remain wet for 30 seconds and allowed to air dry. DON B indicated contact time for COVID 19 is 30 seconds. Resident #112 Review of the Face Sheet revealed Resident #112 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #113 Review of the Face Sheet revealed Resident #113 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #114 Review of the Face Sheet revealed Resident #114 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #115 Review of the Face Sheet revealed Resident #115 was an [AGE] year-old male admitted to the facility on [DATE]. Resident #116 Review of the Face Sheet revealed Resident #116 was an [AGE] year-old male admitted to the facility on [DATE]. Resident #117 Review of the Face Sheet revealed Resident #117 was an [AGE] year-old female admitted to the facility on [DATE]. Resident #118 Review of the Face Sheet revealed Resident #118 was a [AGE] year-old female admitted to the facility on [DATE]. During an observation on 9/1/20 at 3:30 PM, Laundry Attendant O (LA) entered the facility and began delivering laundry. LA O delivered laundry to Resident #112, #113, #114, #115, ##116, #117, and #118. LA O did not perform hand hygiene prior to entering each resident's room and did not perform hand hygiene when exiting each resident's room. As LA O moved through the facility and while left unattended the laundry cart remained open to air. Resident #119 Review of the Face Sheet revealed Resident #119 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #119 was on transmission-based droplet precautions. Resident #120 Review of the Face Sheet revealed Resident #114 was an [AGE] year-old female admitted to the facility on [DATE]. Resident #120 was on transmission-based droplet precautions. During an observation on 9/1/20 at 3:40 PM, LA P entered the facility and began delivering laundry to the droplet precautions hall. LA P delivered laundry to Resident #119 and #120. LA P did not perform hand hygiene prior to entering each resident's room and did not perform hand hygiene when exiting each resident's room. LA P did not don a gown or gloves when entering Resident #119 and #120's room to adhere to droplet precautions. LA P carried linen against the body when delivering to both residents. In an interview on 9/1/20 at 3:45 PM, LA O indicated when delivered laundry did not perform hand hygiene in and out of each resident room. LA O indicted when entering a droplet precautions room should wear gown, gloves, mask, and face shield; and should perform hand hygiene before donning gown and gloves and after doffing gown and gloves. Resident #104 Review of the Face Sheet revealed Resident #104 was an [AGE] year-old female admitted to the facility on [DATE]. Resident #105 Review of the Face Sheet revealed Resident #105 was an [AGE] year-old female admitted to the facility on [DATE]. Resident #106 Review of the Face Sheet revealed Resident #106 was a [AGE] year-old male admitted to the facility on [DATE]. During an observation on 9/1/20 at 1:05 PM, Residents #104 and #105 were seated at table eating lunch in the hallway seated approximately 6 feet apart. There was a third lunch placed in between the two residents. LPN I pushed Resident #106 to table the table in between Resident #104 and #105. The residents were now seated approximately 2 feet from each other eating lunch. All three residents remained seated at the table for approximately 45 minutes. No attempt to separate residents at least 6 feet apart were made by staff. No demand by Resident #106 to remain seated at this lunch table was heard. Several other tables 6 ft away were empty and available. In an interview on 9/1/20 at 1:50 PM, LPN I indicated Resident #104 and #105 always eat lunch at the table in the hallway. They start separated about 6 feet apart and then slowly creep right next to each other. LPN I indicated does

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) not even try to separate them anymore. Resident #106 does not typically sit at this table, but he was insistent on eating lunch with the Resident #104 and #105. LPN I indicted Resident #106 was discharging today.
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow CDC guidelines for [DIAGNOSES REDACTED]-CoV-2 specimen testing for 3 of 3 staff member, reviewed for specimen collection, resulting in the potential for the spread of infectious diseases and initiating an outbreak of COVID 19. Findings include: Review of the Center for Disease Control (CDC) recommendations Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for COVID-19, last revised 7/18/20, revealed, . Collecting and Handling Specimens Safely .For providers collecting specimens or within 6 feet of patients suspected to be infected with [DIAGNOSES REDACTED]-CoV-2, maintain proper infection control and use recommended personal protective equipment (PPE), which includes an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown, when collecting specimens . https://www.cdc.gov/coronavirus/2019-ncov/lab/guidelines-clinical-specimens.html Review of the facility's policy Specimen Testing for [DIAGNOSES REDACTED]-CoV-2, dated 4/2020, revealed .To promote proper collection of specimens . Preparation and Equipment: .Obtain personal protective equipment (PPE) including: Gown, nonsterile gloves: protective mask: face shield . During an observation on 9/1/20 at 12:15 PM, Unit Manager C (UM) was conducting a COVID 19 nasopharyngeal (up the nose) swab test for Housekeeper D. UM C wore a mask, face shield, and gloves, standing less than 1 foot from Housekeeper D, and inserted the COVID 19 testing swab into Housekeeper D's nares. No gown was observed. During an observation on 9/1/20 at 12:20 PM, UM C was conducting a COVID 19 swab test for Certified Nursing Assistant E (CNA). UM C wore a mask, face shield, and gloves, standing less than 1 foot from CNA E, and inserted the COVID 19 testing swab into CNA E nares. No gown was observed. During an observation on 9/1/20 at 12:20 PM, UM C was conducting a COVID 19 swab test for CNA F. UM C wore a mask, face shield, and gloves, standing less than 1 foot from CNA F, and inserted the COVID 19 testing swab into CNA F nares. In an interview on 9/2/20 at 1:00 PM, UM C indicated did not wear a gown while testing the staff for COVID 19 and should have per facility and CDC guidelines. In an interview on 9/2/20 at 11:00 AM, Director of Nursing B (DON) indicated when the nurses test the residents and staff for COVID 19, they are expected to wear a mask, face shield, gown, and gloves.