STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235038	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PILGRIM MANOR	2000 LEONARD N E GRAND RAPIDS, MI 49505

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 141. Based on observation, interview, and record review, the facility failed to develop and/or implement a comprehensive, person-centered care plan consistent with the resident care needs in 1 resident (Resident #101) of 11 sampled residents reviewed for care-planned interventions, resulting in Resident #101's care plan not being updated after a fall, a fall with fracture, and the potential for residents not meeting their highest practicable level of well-being. Findings include: Review of Resident Directed Care Planning Policy & Procedure Approved/Origination 11/22/16, revealed, POLICY The Interdisciplinary Team (IDT) shall develop a baseline care plan for each resident that includes the instructions needed to provide effective and resident-directed care of the resident that meets professional standards of care. PROCEDURE The baseline care plan shall . 4. A comprehensive care plan must be . c. Reviewed and revised by the IDT after each assessment, including both the comprehensive and quarterly review assessments . 5. The services provided or arranged by the IDT must: Meet professional standards of quality . Review of facility policy Fall Management Reviewed Date: Reviewed Date: 3/3/2017, revealed, Policy: This community is dedicated to providing the best possible care to our residents. Safety is a priority to our mission. All residents admitted to our community are considered at risk for falls. Our efforts are focused on minimizing fall risk and fall related injuries, while maximizing individual dignity freedom and quality of life. Procedure: A fall risk assessment will be completed on all residents on admission, readmission, quarterly, significant change of condition, and following each fall. The fall risk assessment will include assessment of medications, vision, mobility, unsafe behavior, pain and ADL functional status. Fall management interventions are based on the overall assessment, history and physical examination [REDACTED]. Interventions are monitored for effectiveness and modified from admission, quarterly, significant change of condition, and following each fall. A Care Plan is developed to provide proactive interventions to address individualized needs based on the CAA's, fall risk assessment and responsible party input . If a resident falls, despite interventions, the following will occur . The new intervention will be implemented by the unit staff as soon as possible . An acute fall care plan will be completed to include the new preventative measures. If an acute fall care plan is already in place, the care plan will be updated with new preventive measures . Review of Fundamentals of Nursing (Potter and Perry) 8th edition revealed, Assessment is a continuous process that occurs each time you interact with a patient .after reassessing a patient, review the care plan and compare assessment data to validate the nursing [DIAGNOSES REDACTED]. If the patient's status has changed and the nursing [DIAGNOSES REDACTED]. An out-of-date or incorrect care plan compromises the quality of nursing care. Review and modification enable you to provide timely nursing interventions to best meet the patient's needs. Potter, P.A., Perry, A. G., Stockert, P.A., & Hall. A. (2014). Fundamentals of Nursing (8th ed.). St. Louis: Mosby. P. 256-257 Review of facility-reported incident MI 141 indicated on 4/22/2020 at 8:42 AM, Resident #101 had a fall that resulted in injury. Review of a Face Sheet revealed Resident #101 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 4/22/2020, revealed a Brief Interview for Mental Status (BIMS) score of 5, out of a total possible score of 15, which indicated Resident #101 was severly cognitively impaired. Further review of the MDS indicated Resident #101 was at risk for falls and required a walker for mobility. Review of Resident #101's Care Plans revealed, Focus: risk for falls related to history of falling, impaired mobility, positive Fall Risk Assessment and confusion and impulsivity. Date Initiated: 2/27/2020 .Goal: I will have no falls and/or fall related injuries through the review date Date Initiated: 2/27/2020 .Interventions . OT screen for room set up/clear pathways Date Initiated: 04/10/2020 . PT/OT referral Date Initiated: 03/10/2020 .Focus . ADL self-care performance deficit related to altered respiratory status, decreased endurance, generalized weakness/deconditioning Date Initiated: 02/27/2020 .Goal .I will improve level of function through the review date. Date Initiated: 2/27/2020 .Interventions .AMBULATION: I walk with minimum assist with 4 WW (wheeled walker) short distances due to impulsivity. Date Initiated: 03/10/2020 . Noted Resident #101 fell on [DATE] resulting in a fracture and did not return to the facility. Review of Resident #101's Kardex Report as of 7/12/2020 (certified nursing assistant (CNA)) care guide to direct resident care) revealed, .ADL's (activities of daily living) AMBULATION . walk with minimum assist with 4 WW (4 wheeled-walker) for short distances due to impulsivity . TRANSFER . require minimal staff assistance with transfers . MONITORING Assist with mobility as needed . SAFETY Keep frequent needed items within reach, Keep my call light within reach and remind me to use it .OT screen for room set up/clear pathways . MISCELLANEOUS .Avoid Clutter Review of Resident #101's Fall Risk assessment dated [DATE] 17:34 revealed the assessment was for an Admission and indicated the resident was a High-Risk with a Score of 10 and 1-2 falls in past 3 months. Review of Resident #101's Fall Risk assessment dated [DATE] 23:51 revealed the assessment was for an Admission and indicated the resident was a High-Risk with a Score of 10 and 1-2 falls in past 3 months. Review of Resident #101's Fall Risk assessment dated [DATE] 08:55 revealed the assessment was for a description of other(related to fall dated 4/9/2020) indicating the resident was High-Risk with a Score of 14 intermittent confusion 1-2 falls in past 3 months with the resident unable to perform function when staff attempted to assess the resident's Gait/Balance, have him/her stand on both feet without holding onto anything; walk through a doorway; and make a turn. Review of Resident #101's Unusual Incident Report #984 dated 4/9/2020 08:55 indicated the resident was walking in room and tripped and fell . The Immediate Action Taken revealed after review of resident's fall care plan updated to reflect fall intervention of OT screen for room set-up with clear pathways. Review of Resident #101's Unusual Incident Report #988 dated 4/16/2020 10:30 indicated the resident going over to help her roommate . stated she fell on her butt. The Immediate Action Taken revealed .educated on call-light use. Resident placed on 30-minute checks. Further review of the report revealed Resident #101 had predisposing psychological risk factor of confused gait imbalance and impaired memory. Noted that a Fall Risk Assessment was not completed for this fall. Review of Resident #101's Progress Note dated 4/16/2020 at 11:05 revealed, Resident found on the floor .Resident placed on 30-minute checks Will continue to monitor . Noted that Resident #101's Care Plan and Kardex did not reflect the intervention of 30-minute checks was added. Review of Resident #101 Unusual Incident Report dated 4/22/2020 at 09:32 (9:32 AM) indicated the resident was in her room and used her 4 WW to get up to get a cup of coffee and fell while sustaining a right hip/leg injury. Further review of the report revealed Resident #101 had predisposing psychological risk factor of impaired memory and was aware this was her third fall recently. Review of witness statement dated 4/24/2020 at 8:42 AM from Housekeeping C revealed, I saw her fall. She was sitting on the edge of her bed and she got up to walk. She twisted her feet, I think she was trying to turn around, her ankles crossed over each other and she fell right over. She landed with her walker under her shoulder. I ran to try and catch her, but I didn't get there in time. During an interview on 7/7/2020 at 9:40 AM Director of Nursing (DON) B stated, (Resident #101) fell in her room and broke her leg. A housekeeper was in the room and could not get to her in time to avoid the fall. During an interview on 7/8/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) at 10:04 AM Unit Manager (UM) F stated, (Resident #101) fall on April 22 (2020) got up to talk to her roommate and forget to use her walker. She would use her walker 75% of the time and would have to be reminded. (Resident #101) had a history of [REDACTED]. Care plans generate the information for the Kardex. With (Resident #101) prior falls, her intervention update on the care plan would be made by the team taking care of her at that time, myself and the nurse, or the IDT would follow-up with interventions as well. The importance of the care plan is a reference tool for the resident's safety and care. The care plan should be updated immediately after any time of occurrence. The expectations of staff is to know what is on the care plan and to follow it. During an interview on 7/8/2020 at 11:59 PM CNA D stated, (Resident #101) did not call for help with her call-light when she needed it. She did not use the call-light. Staff reminded her all the time to use her call-light. The housekeeping staff was already in her room when she fell in April (4/22/2020). I was the room next door coming towards (Resident #101) room. The housekeeper told me (Resident #101) had just fallen. CNA staff knew (Resident #101) was a fall risk but I do not know if housekeeping was told. I would do frequent checks on her when I went past her room because I knew she was a fall risk. I had heard that she had falls before. Frequent checks were not on her Kardex. Information on the Kardex is in the computer. It pulls up information that is needed for aides (CNA) to care for the resident. I can always go to the nurse or nurse manager and let them know what I observed of a resident's behavior. If (Resident #101) got antsy I would sit with her and help her calm down. She moved fast when she was up on her feet. During an interview on 7/8/2020 at 1:10 PM, Housekeeping C stated, I do not work at the facility anymore. I do not want to talk about what happened. During an interview on 7/9/2020 at 1:11 PM with Rehab Director (RD) K and Certified Occupational Therapy Assistant (COTA) L, RD K stated, (COTA L) and I worked with (Resident #101) in the past. COTA L stated, An OT (occupational therapy) screen is done using a form. Nursing will typically send the referral for an OT screen. RD K stated, Nursing will either put the form in the Rehab Director's mailbox or physically hand it to me. I would do the OT screen to see if the resident were appropriate for the evaluation. COTA L did a record review of Resident #101's therapy notes to look for documentation and stated, I don't see an OT screen that has been uploaded into the electronic documentation. RD K stated, I would be responsible for scanning documents into the electronic medical records. I do not think I have received any paper referral forms since I have started beginning of April (2020). Typically, when Grand Rounds are done with the IDT, we discuss resident needs and that is when a referral would be discussed. I have a tracking form I use during Grand Rounds. I keep the tracking forms. The forms were kept starting about May 1, 2020. COTA L stated, (Resident #101) needed staff help for transfers and ambulation. She was impulsive and had difficulty following directions. She often transferred herself with poor safety. The therapy department has a Therapy Communication Form that communicates recommendations to nursing. We do not enter them into the care plan. Nursing enters therapy's recommendation into the resident's care plan. Review of email communication received 07/09/2020 3:08 PM from RD K stated, I was unable to find evidence that we (therapy) were given a referral for (Resident #101) for 4/10/20. It is noted Resident #101 did not receive screening for OT. The 30-minute checks should be on her care plan and Kardex if indicated as an intervention. Review of Resident #101's care plan and Kardex revealed the 30-minute checks were not initiated. During an interview on 7/14/2020 at 1:10 PM, MDS Coordinator (MDS) N stated, When the IDT (interdisciplinary team) does Grand Rounds (IDT discusses residents) and there is a change with a resident's care, someone will put the change in the care plan. I must have been the one that day who entered (Resident #101's) change in the care plan. I don't follow through to make sure the care plans are followed; the unit manager or resident's nurse does. It was noted that Resident #101's Care Plans did not reflect a comprehensive plan of care to include frequent monitoring and 30-minute checks directly related to her impulsiveness and impaired memory.
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 141 Based on observation, interview, and record review, the facility failed to implement safety interventions and adequate supervision to prevent a fall with injury for 1 resident (Resident #101) of 11 sampled residents reviewed for falls, resulting in a fall with femur fracture and the decreased potential to preventing further falls with injuries. Findings include: Review of facility policy Fall Management Reviewed Date: Reviewed Date: 3/3/2017, revealed, Policy: This community is dedicated to providing the best possible care to our residents. Safety is a priority to our mission. All residents admitted to our community are considered at risk for falls. Our efforts are focused on minimizing fall risk and fall related injuries, while maximizing individual dignity freedom and quality of life. Procedure: A fall risk assessment will be completed on all residents on . following each fall .Fall management interventions are based on the overall assessment, history and physical examination [REDACTED]. Interventions are monitored for effectiveness .and following each fall .If a resident falls, despite interventions, the following will occur . The new intervention will be implemented by the unit staff as soon as possible . An acute fall care plan will be completed to include the new preventative measures. If an acute fall care plan is already in place, the care plan will be updated with new preventive measures . Review of intake MI 141 indicated on 4/22/2020 at 8:42 AM, Resident #101 fell and sustained an injury. Review of Resident #101's Unusual Incident Report #988 dated 4/16/2020 10:30 indicated the resident going over to help her roommate . stated she fell on her butt. The Immediate Action Taken revealed .educated on call-light use. Resident placed on 30-minute checks. Further review of the report revealed Resident #101 had predisposing psychological risk factor of confused gait imbalance and impaired memory. Noted that a Fall Risk Assessment was not completed for this fall. Review of Resident #101's Progress Note dated 4/16/2020 at 11:05 revealed, Resident found on the floor .Resident placed on 30-minute checks Will continue to monitor . Noted that Resident #101's Care Plan and Kardex did not reflect the intervention of 30-minute checks was added. Review of Resident #101 Unusual Incident Report #992 dated 4/22/2020 at 09:32 (9:32 AM) indicated the resident was in her room and used her 4 WW to get up to get a cup of coffee and fell while sustaining a right hip/leg injury. Further review of the report revealed Resident #101 had predisposing psychological risk factor of impaired memory and was aware this was her third fall recently. Noted that a Fall Risk Assessment was not completed for this fall. Review of witness statement dated 4/24/2020 at 8:42 AM from Housekeeping C revealed, I saw her fall. She was sitting on the edge of her bed and she got up to walk. She twisted her feet, I think she was trying to turn around, her ankles crossed over each other and she fell right over. She landed with her walker under her shoulder. I ran to try and catch her, but I didn't get there in time. Review of a Face Sheet revealed Resident #101 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 4/22/2020, revealed a Brief Interview for Mental Status (BIMS) score of 5, out of a total possible score of 15, which indicated Resident #101 was cognitively impaired. Further review of the MDS revealed Resident #101 was at risk for falls and required a walker to assist with mobility. Review of Resident #101's Care Plans revealed, Focus: risk for falls related to history of falling, impaired mobility, positive Fall Risk Assessment and confusion and impulsivity. Date Initiated: 2/27/2020 .Goal: I will have no falls and/or fall related injuries through the review date Date Initiated: 2/27/2020 .Interventions . OT screen for room set up/clear pathways Date Initiated: 04/10/2020 . PT/OT referral Date Initiated: 03/10/2020 .Focus . ADL self-care performance deficit related to altered respiratory status, decreased endurance, generalized weakness/deconditioning Date Initiated: 02/27/2020 .Goal .I will improve level of function through the review date. Date Initiated: 2/27/2020 .Interventions .AMBULATION: I walk with minimum assist with 4 WW (wheeled walker) short distances due to impulsivity. Date Initiated: 03/10/2020 . Noted Resident #101 fell on [DATE] resulting in a fracture and did not return to the facility. Review of Resident #101's Kardex Report as of 7/12/2020 (certified nursing assistant (CNA)) care guide to direct resident care) revealed, .ADL's (activities of daily living) AMBULATION . walk with minimum assist with 4 WW (4 wheeled-walker) for short distances due to impulsivity . TRANSFER . require minimal staff assistance with transfers . MONITORING Assist with mobility as needed . SAFETY Keep frequent needed items within reach, Keep my call light within reach and remind me to use it .OT screen for room set up/clear pathways . MISCELLANEOUS .Avoid Clutter During an interview on 7/7/2020 at 9:40 AM, Director of Nursing (DON) B stated, (Resident #101) fell in her room and broke her leg. A housekeeper was in the room and could not get to her in time to avoid the fall. During an interview on 7/8/2020 at 10:04 AM Unit Manager (UM) F stated, (Resident #101) fall on April 22 (2020) got up to talk to her roommate and forget to use her walker. She would use her walker 75% of the time and would have to be reminded. (Resident #101) had a history of [REDACTED].#101) The housekeeping staff was already in her room when she fell in April (4/22/2020). I was the room next door coming towards (Resident #101) room. The housekeeper told me (Resident #101) had just fallen. CNA staff knew (Resident #101) was a fall risk but I do not know if housekeeping was told.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) During an interview on 7/8/2020 at 1:10 PM, Housekeeping C stated, I do not work at the facility anymore. I do not want to talk about what happened. During an interview and record review on 7/14/2020 at 10:10 AM with Registered Nurse (RN) U stated, (Resident #101) did not use her call-light like she should and would just get up off her bed and walk. She fell a few times in a row and did not use her call-light each time. She was put on 30-minute checks for closer monitoring. CNAs were told she was on fall report. Fall Report is when vital signs are done for 3-days along with neurological checks. Review of Resident #101's Care Plans with RN U revealed the intervention of 30-minute checks was not added after stated in Unusual Incident Report #988 and Progress Note dated 4/16/2020 11:05.
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**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 ensure infection control practices per CDC (Centers for Disease Control) recommendations for COVID-19 of hand hygiene and proper PPE (personal protection equipment) implementation for 9 of 9 residents, (Resident #102, #103, #105, #106, #107, #108, #109, #110, and #111) reviewed for infection control, resulting in an immediate jeopardy when, while not following contact and droplet precautions to prevent the spread of respiratory illness, COVID-19, beginning on 6/18/20, facility staff did not perform surveillance or follow the CDC guidance to prevent the spread of Covid-19 to residents in the facility This deficient practice placed all residents residing in the facility at risk for serious harm and/or death. On 7/8/2020 at 2:31 PM, the Nursing Home Administrator was verbally notified and received written notification of the immediate jeopardy that began on 6/18/2020 due to the facility's failure to implement infection control in the designated COVID-19 unit. A written plan for removal for the immediate jeopardy was received on 7/8/2020 and the following was verified on 7/14/2020. 1. Staff that were observed and/or identified during the observations have been in serviced on maintaining infection control standards which included Hand Hygiene and proper use of PPE. 4 of the 6 involved have received in service training as of July 9, 2020 by the Director, Nursing Services. The remaining 2 will be in service trained before the start of the next assigned shift. 2. As of July 10, 2020, Residents on the Covid 19 unit will have a daily respiratory assessment completed as recommended by the CDC. If a resident becomes symptomatic the medical director will be notified for treatment/testing orders and identified as possibly COVID-19 positive. 3. Initial testing of residents to meet the baseline testing was completed June 20, 2020 with no subsequent positive results being identified. Additionally, all residents in the community are tested based on the June 15, 2020 (state name) Department of Health and Human Services communication, which currently recommends weekly testing for COVID 19. Weekly testing of residents began July 10, 2020 in which all residents tested negative. Staff testing was initially completed on June 26, 2020 followed by July 1, 2020 and last tested on [DATE] with all staff testing negative. Next weekly testing of Staff is July 15, 2020. 4. The County Health Department has been consulted with to obtain input on its layout and development on 7/13/2020. All guidance from the County Health Department has been incorporated into the COVID unit plan. Based on recommendations as indicated by the CDC, a temporary barrier will be installed on 7/13/2020 in the area encompassing rooms [ROOM NUMBERS] to contain COVID 19 positive residents as well as persons under investigation. This temporary barrier physically separates these rooms from the rest of the community and will be staffed with a dedicated staff member to provide care to these residents when these rooms are occupied or in use. Signage will be installed on this physical barrier to indicate positive COVID-19 residents are within. 5. Appropriate signage which consists of a STOP sign, a droplet isolation indication sign, and PPE use sign has been affixed to all resident room doors as of 7/10/2020. 6. Staff will be in serviced by Director, Nursing Services or designee on the following policies and procedures: -Hand Hygiene / Handwashing (Staff who are assigned to the Covid 19 Unit will be in serviced prior to their next scheduled shift.) 30 of the 99 staff have been in serviced as of July 9, 2020. As of July 13, 2020, 91 of 103 community staff members and providers have been in serviced. For all remaining, none will be allowed to work without receiving the necessary education. -Proper selection and use of PPE (Staff who are assigned to the Covid 19 Unit will be in serviced prior to their next scheduled shift.) 30 of the 99 staff have been in serviced as of July 9, 2020 As of July 13, 2020, 91 of 103 community staff members and providers have been in serviced. For all remaining, none will be allowed to work without receiving the necessary education. -Inservice of the facility policy and procedure for the Covid 19 unit. (Staff who are assigned to the Covid 19 Unit will be in serviced prior to their next scheduled led shift.) 30 of the 99 staff have been in serviced as of July 9, 2020 As of July 13, 2020, 91 of 103 community staff members and providers have been in serviced. For all remaining, none will be allowed to work without receiving the necessary education. 7. Effective July 11, 2020 Director of Nursing, or designee, will complete routine audits of hand hygiene, PPE usage, and general infection control practices with a frequency of 2 times a shift, every shift, ongoing until otherwise directed by the QA/QAPI committee. Audits will be reviewed with QA/QAPI to determine need of audit modification and further interventions to improve and maintain infection control processes. Although the immediate jeopardy was removed as of 7/13/2020, the facility remained out of compliance at a scope of isolated and severity of no actual harm with the potential for more than minimal harm that is not immediate jeopardy due to the fact that not all facility staff have received education and sustained compliance had not been verified by the State Agency. Findings include: According to CDC (Centers for Disease Control) https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html, .Identify Space in the Facility that Could be Dedicated to Monitor and Care for Residents with 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 professional) who will be assigned to work only on the COVID-19 care unit when it is in use. Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, implement use of Transmission-Based Precautions, prioritize for testing, transfer to COVID-19 unit if positive). Residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room pending results of [DIAGNOSES REDACTED]-CoV-2 testing. They should not be placed in a room with a new admission nor should they be moved to the COVID-19 care unit unless they are confirmed to have COVID-19 by testing. While awaiting results of testing, HCP 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 . According to CDC https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html, .Resident Cohorting: Considerations for establishing a designated COVID-19 care unit for residents with confirmed COVID-19: -Determine the location of the COVID-19 care unit and create a staffing plan before residents or HCP with COVID-19 are identified in the facility. This will allow time for residents to be relocated to create space for the unit and to identify HCP to work on this unit -Ideally the unit should be physically separated from other rooms or units housing residents without confirmed COVID-19 -Assign dedicated HCP to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (NAs) (identified as CNA (certified nursing assistant in the facility) and nurses assigned to care for these residents. HCP working on the COVID-19 care unit should ideally have a restroom, break room, and work area that are separate from HCP working in other areas of the facility . -Place signage at the entrance to the COVID-19 care unit that instructs HCP they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms -Ensure that HCP have been trained on infection prevention measures, including the use of and steps to properly put on and remove recommended personal protective equipment (PPE) . According to https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html, Cohorting is the practice of grouping residents infected or colonized with the same infectious agent together to confine their care to one area and prevent contact twith susceptible residents (cohorting residents). During outbreaks, healthcare staff may be assigned to a specific cohort of residents to further limit opportunities for transmission (cohorting staff). The terms cohort or cohorting is standardized language used in the practice of infection prevention and control; the use of this terminology is not intended to offend residents or staff. According to CDC https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf, . I.B.3.b. Droplet transmission. Droplet transmission is, technically, a form of contact transmission, and some infectious agents transmitted by the droplet route also may be transmitted by the direct and indirect contact routes .in contrast to contact transmission, respiratory droplets carrying infectious pathogens transmit infection when they travel directly from the respiratory tract of the infectious individual to susceptible mucosal surfaces of the recipient, generally over short distances, necessitating facial protection. Respiratory droplets are generated when an infected person coughs, sneezes, or talks .Examples of infectious agents that are transmitted via the droplet route include .[DIAGNOSES REDACTED]-associated coronavirus ([DIAGNOSES REDACTED]-CoV) . Although respiratory [MEDICAL CONDITION] may be transmitted by the droplet route, direct

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) contact with infected respiratory secretions is the most important determinant of transmission and consistent adherence to Standard plus Contact Precautions prevents transmission in healthcare settings .I.B.3.d.i. Transmission from patients .Although [DIAGNOSES REDACTED]-CoV is transmitted primarily by contact and/or droplet routes, airborne transmission over a limited distance (e.g., within a room) . I.D.2.a. Long-term care. The designation LTCF applies to a diverse group of residential settings, ranging from institutions for the developmentally disabled to nursing homes for the elderly .LCTFs are different from other healthcare settings in that elderly patients at increased risk for infection are brought together in one setting and remain in the facility for extended periods of time; for most residents, it is their home .Risk factors for infection are prevalent among LTCF residents .Upon identification of a potentially infectious patient, implementation of prevention measures, including prompt separation of potentially infectious patients and implementation of appropriate control measures (e.g., .Respiratory Hygiene/Cough Etiquette and Transmission-Based Precautions) can decrease transmission risks .I.E.1. Immunocompromised patients. Patients who have congenital primary immune deficiencies or acquired disease (eg. treatment-induced immune deficiencies) are at increased risk for numerous types of infections while receiving healthcare and may be located throughout the healthcare facility. II.A.3. Adherence of healthcare personnel to recommended guidelines. Adherence to recommended infection control practices decreases transmission of infectious agents in healthcare settings .II.E. Personal Protective Equipment (PPE) for Healthcare Personnel .PPE refers to a variety of barriers and respirators used alone or in combination to protect mucous membranes, airways, skin, and clothing from contact with infectious agents. The selection of PPE is based on the nature of the patient interaction and/or the likely mode(s) of transmission .II.E.2. Isolation gowns. Isolation gowns are used as specified by Standard and Transmission-Based Precautions, to protect the HCW's (health-care worker) arms and exposed body areas and prevent contamination of clothing with .potentially infectious material .Isolation gowns should be removed before leaving the patient care area to prevent possible contamination of the environment outside the patient's room . According to https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html Contact precautions are measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. Droplet precautions are actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. According to CDC (Centers for Disease Control) at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, revealed, Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at high risk of being affected by respiratory pathogens like COVID-19 .As demonstrated by the COVID-19 pandemic, a strong infection prevention and control (IPC) program is critical to protect both residents and healthcare personnel (HCP). Facilities should assign at least one individual with training in IPC to provide on-site management of their COVID-19 prevention and response activities because of the breadth of activities for which an IPC program is responsible, including developing IPC policies and procedures, performing infection surveillance, providing competency-based training of HCP (health care professional), and auditing adherence to recommended IPC practices . Core Practices These practices should remain in place even as nursing homes resume normal activities. Assign One or More Individuals with Training in Infection Control to Provide On-Site Management of the IPC Program .Smaller facilities should consider staffing the IPC program based on the resident population and facility service needs . Review of facility policy (Facility Name) COVID-19 PROCEDURE POLICY date not known, revealed, TRANSMISSION-BASED PRECAUTIONS 1. Follow recommendations of CDC. 2. Follow recommendations of CMS. 3. Follow recommendations of Health Department .9. For a resident with known or suspected COVID-19 .E. Signage will be posted outside of Residents room with use of specific PPE . Review of facility policy, Infection Control Approved/Origination Date: 03/26/2018, revealed, Position Statement (facility name) has established and will maintain an ongoing facility-wide infection prevention and control program (IPCP) designed to provide a safe, sanitary, and comfortable environment that promotes the prevention of development and transmission of communicable diseases and infections. The IPCP will include an ongoing system of surveillance designed to identify possible communicable disease or infections to prevent the spread to other persons in the facility. Rationale: Healthcare associated infections (HAIs) can cause significant pain and discomfort for residents in long-term care facilities (LTCFs) and can have significant adverse consequences. Serious infections are a major cause of hospitalization and death annually. Infection prevention and control practices are important in maintaining a safe environment by reducing the risk of the potential spread of disease from person to person. These practices are designed to reduce the risk of HAIs and to ensure a safe and healthy environment for residents, .and healthcare staff .Infection Prevention and Control Policies and Procedures (facility name) has developed and implemented written policies and procedures for the provision of infection prevention and control. The facility .Infection Preventionist will ensure that current standards of practice based on recognized guidelines and best evidence are incorporated in the policies and procedures. Policies and procedures will guide nursing .practices .Surveillance (facility name) has established a system for surveillance based upon national standards of practice and the facility assessment, including the resident population and the services and care provided. Surveillance encompasses routine, ongoing, and systematic collection, analyses, interpretation, and dissemination of surveillance data to identify infections, infection risks, communicable disease outbreaks to maintain or improve resident health status. Staff Education and Competency with IPCP (facility name) will ensure that staff will follow the IPCP and all standards, policies, and procedures. Therefore, staff will be informed and competent. Education and training of staff will promote knowledge and skills pertaining to the IPCP and infection control practices . RESIDENT 102 Review of a Face Sheet revealed Resident #102 was a [AGE] year-old female, originally admitted to the facility on [DATE] and had a positive Covid-19 test on 6/18/20 and 7/2/20. RESIDENT 103 Review of a Face Sheet revealed Resident #103 was an [AGE] year-old female, originally admitted to the facility on [DATE] and had a positive Covid-19 test on 6/18/20. During an interview on 7/7/2020 at 9:40 AM Director of Nursing (DON) B stated, There are 2 (two) residents in the facility that are COVID-19 positive. (Resident #102 and Resident #103). (Resident #103) was put on hospice after the [DIAGNOSES REDACTED]. I do not know how they got [MEDICAL CONDITION]. (Resident #102 and Resident #103) were roommates. They are now on the designated COVID-19 isolation unit. All residents on that unit are on droplet precautions. There are signs on the unit to tell staff what PPE (personal protection equipment) is required when entering the unit. Staff enters a vestibule and is required to don a N95 mask (tight-fitting respirators that filter out at least 95% of particles in the air, including large and small particles) and eye covering before entering the unit. Both quarantined, and positive COVID-19 residents are in the unit. There is no plastic wall or anything that separates the quarantined residents from the positive COVID-19 resident rooms. Staff takes care of the two (2) positive COVID-19 residents and the seven (7) quarantined residents. During the pandemic, the facility works with the local health department, CDC (Centers for Disease Control), and Region 6. During an observation and interview on 7/7/2020 at 1:40 PM, toured with DON B the identified designated COVID-19 isolation unit. Upon entering the vestibule between 2 (two) zip-walls (plastic wall with zippers), there were tables that held gloves, masks, goggles, hand sanitizer, and disinfectant wipes. Under the tables were boxes of gowns. On the zip-wall leading directly into the COVID unit were signage explaining what PPE was required to enter the unit, what PPE was required when coming into direct contact with the residents on contact and droplet isolation, and directions for dining, laundry, and housekeeping staff. On the vestibule walls hung plastic bags for each employee to hold employee specific N95 masks and face shields. To enter directly into the designated COVID-19-unit signage stated STOP stating that a N95 mask and eye-covering was were required. DON B stated, The vestibule leading into the COVID unit between the 2-zipwalls is where staff puts on PPE before entering The Nest. The Nest is what the facility calls the designated COVID-19 unit. There is signage indicating a N95 respirator mask and face shield or eye covering is required to enter the unit. On each resident door you will see there is signage telling staff to not enter a room without first talking to a nurse and stating the resident is on droplet precautions. There is no signage to designate which resident is COVID-19 positive and which resident is on quarantine. I set-up the COVID-19 unit. The quarantined residents are either new or re-admit residents and are on the unit for 14-days. All but one of the current quarantine residents were tested for COVID-19 with negative results at the hospital before coming into the facility. One resident, (Resident # 107), was not tested for COVID-19 before she was readmitted to the facility. She is immunocompromised (impaired immune system). After acquiring required PPE, surveyor entered COVID unit with DON B into a staging-unit where N95 mask and face-shield were donned. The unit main area was an open concept with resident rooms circling on 3 (three) sides with a total of 9 (nine) resident rooms. The nursing station and utility rooms were to the left of the entrance. To the right of the entrance, beyond the common area, were 2 (two) rooms with doors closed. All other resident rooms had doors open into the common area. DON B stated, These 2 (rooms) are where the COVID-positive residents, (Resident #102 and #103) are at. Their doors are always to be closed. All resident doors on this unit should always be closed. Observed on Resident #102 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235038	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PILGRIM MANOR	2000 LEONARD N E GRAND RAPIDS, MI 49505

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) Resident #103 doors were signage directing people to STOP and see the nurse before entering the room. The other sign on the doors designated the resident in the room was on droplet precautions. DON B stated, I set-up this area. I did not have any more zip-walls to put around the positive COVID residents. The facility was trying to keep the cost down. Resident #108 Review of a Face Sheet revealed Resident #108 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. During an observation and interview on 7/7/2020 at 1:40 PM while with DON B on the COVID unit, next to Resident #102's room was Resident #108's room. The resident's door was open with Physician H and Unit Manager (UM) F in with him. Physician H was wearing a dark colored gown, gloves, mask, and face shield. Unit Manager (UM) F wore similar PPE as Physician H, with her gown a light blue. DON B stated, (Resident #108) is a new admit. (Physician H and UM F) are evaluating him. The door should be closed. Gowns are assigned to each staff for each resident room daily. The gown is to be kept in the resident room and disposed of at the end of the staff's shift. You will not see any staff enter a room without or this unit without a N95 (mask) or face shield. It is automatic staff wear one. Resident #111 Review of a Face Sheet revealed Resident #111 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. During an observation and interview on 7/7/2020 at 1:45 PM, while on COVID unit with DON B, Central Supply Assistant (CSA) P was outside of Resident #111's door shaking open a red biological-hazard (bio-hazard) bag. Admissions Coordinator (AC) Q was inside resident's room wearing a N95 mask, face shield, gloves, and a light blue plastic-like gown. DON B stated, The bags should not be shaken open even clean, it could spread [MEDICAL CONDITION] particles. During an observation on 7/7/2020 at 2:10 PM while on the COVID unit, Admissions Coordinator (AC) Q exited Resident #111's room while wearing gloves, gown, face shield, and N95 mask and not performing hand hygiene. She gathered up clean linen from across the unit's common area and re-entered the room with the same gloves and gown on and did not perform hand hygiene. AC Q could not answer surveyor's question on why it was important to change gown and gloves before exiting an isolation room and perform hand hygiene when entering or exiting a resident's room. During an interview on 7/7/2020 at 2:12 PM, LPN R stated, Staff should take off gown and gloves and do hand hygiene before entering and upon exiting a resident's room because of infection control risk. During an interview on 7/7/2020 at 2:10 PM, CSA P while on the COVID unit stated, I've had training on droplet precautions. The facility's corporate office sent over aerosol training. Staff was told breathing treatments is high-flow and can spread [MEDICAL CONDITION]. Shaking out a bag is in the facility's general infection control training. I should not have shook the bag out; it could spread the infection. Resident #110 Review of a Face Sheet revealed Resident #110 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. During an observation and interview on 7/7/2020 at 1:50 PM while on the COVID unit with DON B, Licensed Practical Nurse (LPN) R entered Resident #110's room wearing only a N95 mask and face shield. On the resident's door was signage designating the resident as a droplet precaution. It is noted that in the vestibule before entering the COVID unit, signage directs staff that before entering any room, staff should wear the N95 mask, face shield, perform hand hygiene, and don gown and gloves. LPN R stated, I just gave her the phone and threw away her lunch stuff. Resident #106 Review of a Face Sheet revealed Resident #106 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. During observation and interview on 7/7/2020 at 1:55 PM, Physician H exited Resident #108's room without doffing gown and wearing gloves then enter Resident #106's room without closing the door behind her. Surveyor was able to observe Physician H from hallway with Resident #106. Physician H removed resident's socks, touched her lower legs and feet, and replaced the socks. Physician H then pushed up resident's shirt sleeves and examined lower arms and hands. Physician H came to door after being in room with resident for approximately 10 minutes and said to surveyor, This is a COVID room and I am supposed to close the door. Physician H partially shut the door, leaving an estimated 6 (six) inch gap between the door and frame. During an observation and interview on 7/7/2020 at 2:15 PM while on the COVID unit, Physician H exited Resident #106's room without doffing the gown she wore from Resident #108's to Resident #106's room, and went across the hall and entered Resident #107's room. Observed Physician H removing gloves while crossing hall with another pair of gloves underneath them and not performing hand hygiene upon entering Resident #107's room. Resident #107 Review of a Face Sheet revealed Resident #107 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. During an observation and interview on 7/7/2020 at 2:00 PM, Social Worker (SW) S entered Resident #107's room without performing hand hygiene. After speaking with resident, SW S exited the room without performing hand hygiene. SW S stated, I did not do hand hygiene before entering or exiting (Resident #107's) room. Hand hygiene is very important to stop the spread of infection. There is hand sanitizer in the vestibule we can keep with us while on the COVID unit. I've had infection control education and training for COVID. During an interview on 7/7/2020 at 2:10 PM, LPN R stated, Resident doors on this unit (COVID unit) should remain closed at all times. It lessens the risk of air flow and spread of infection. The infection could spread by droplet, fecal, contact and aerosol, especially nebulizer treatments. There should be no fans on in this area and no shaking of bags because [MEDICAL CONDITION] could get on you. During an observation and interview on 7/7/2020 at 2:25 PM while on the COVID unit, Physician H exited Resident #107's room wearing the same gown she had worn in Resident #108's and Resident #106's rooms. Physician H stated, It is important to wear PPE on this unit because there is COVID here. When surveyor asked why she did not change gowns after exiting resident rooms, Physician H stated, I don't have time to answer any more questions and walked away to the nursing station. It was noted that on all resident room doors on the COVID unit signage identifying the resident as a droplet precaution. It was further noted that the zip-wall before entering the COVID unit notified staff to wear N95, face shield, and to don gown, and gloves upon entering a resident room and to leave the gown in the room, remove gloves and perform hand hygiene before exiting the room. During an observation and interview on 7/7/2020 at 2:30 PM while in the COVID vestibule, Registered Nurse (RN) E entered the COVID unit via the vestibule without donning any type of face covering or N95 mask or face shield. At the nursing station RN E donned a surgical paper mask and stated, It is my understanding staff does not have to wear the face shield, eye coverings, or N95 unless going into a resident's room. Surveyor asked RN E to view the notices on the zip-wall with her. Noted that RN E at this time had donned a N95 mask while at the nursing station but did not have on a face shield. Review of signage with RN E revealed two of the facility notices stated, STOP - Know Your PPE stated, To Enter This Unit N95 and Face Shield Are Required. N95s and Face Shields are issued from the med room by the nurse . and NEST UNIT GENERAL INFORMATION .while on the nest unit you must wear eye protection and your N95 mask . RN E stated, My supervisor (UM F) told me I did not have to wear that PPE (N95 and face shield) unless in a resident's room. During an interview on 7/7/2020 at 2:45 PM, DON B stated, Any staff while on the Nest or any room that is isolation precautions should remove gown when exiting the room. When staff go through the zip-wall into the Nest they are expected to wear a N95 mask and face shield/eye protection. All staff education on COVID-19 PPE use has been verbal. There has been staff education online as well. Even (Physician H) has been education numerous times. During an interview on 7/8/2020 at 10:25 AM UM F stated, When staff enter the COVID unit they should have on a N95 mask and either goggles or a face shield. They should have it on to protect themselves from COVID-19. Staff knows it is in that area. The signage at the opening of the unit on the zip-wall notifies staff what PPE to have on before entering that area. Resident doors should be closed to prevent the airflow of [MEDICAL CONDITION]. Besides the PPE signage on the zip-wall, staff has been verbally told and during Huddle (meeting), donning and doffing demonstrations have been done. (Registered Nurse (RN) E) is a RN and has received education and training on COVID-19. They are currently a PRN (as needed) employee. The signage was there for they to know what to wear. During an interview on 7/7/2020 at 9:40 AM, Director of Nursing (DON) B stated, I am in charge of the facility's infection control program. I am the Infection Preventionist. During an interview on 7/9/2020 at 1:00 PM, Nursing Home Administrator (NHA) A stated, (DON B) is the facility Infection Preventionist. She is not certified through the CDC (Centers of Disease Control). During an interview on 7/9/2020 at 1:00 PM, DON B stated, I am the Infection Preventionist for the facility. I am not certified. I have not taken the ICP (Infection Control Preventionist) class online through the CDC website. During a telephone interview on 7/9/2020 at 2:25 PM local health department employee (LHD) M stated, I have 2 (two) cases of COVID-19 on my list dated the week of June 15th for the facility. The facility sent me notification on June 19, 2020 of the positive cases. The facility had been trying to stay in touch but not recently. Resident doors on the designated COVID-19 unit should be shut. The facility should be considering test status results of positive and negative and there should be a separate area for positive residents from the new/re-admits. Residents should be tested before coming into a facility. It is a problem if the resident is not tested before coming into the facility. I and (DON B) went over the COVID-19 checklist for CDC. The checklist did not go over the set-up of the unit and I was not asked for any input. During a telephone interview on 7/10/2020 at 8:58 AM, local health department employee (LHD) M stated, I was told by the facilit