STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235298	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FATHER MURRAY, A VILLA CENTER	**8444 ENGLEMAN CENTER LINE, MI 48015**

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** - 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 properly maintain infection control practices during a COVID-19 Infection Control Survey for one sampled resident (R701), resulting in the potential for the spread of infection and contagion throughout the facility. Findings include: On 8/5/2020 at 9:00 AM, a tour of Unit One North was conducted. Upon observation of One North, the entrance doors to the unit were closed but no signage was in place on the door or wall to indicate R701 was on droplet precaution. A portable over the door PPE [MEDICATION NAME] was present on some, but not all, of the occupied resident rooms. On 8/5/2020 at 9:15 AM, R701 was observed in their room sitting in a wheelchair with several boxes and debris on the floor. No signage was observed upon entry to R701's room. R701 stated, I came from the hospital. I'm trying to get my stuff together but I need help. Upon leaving R701's room, a cart was observed to the right of the room with a sign on a laptop bracket, facing away from the room that had the words STOP in red letters. Licensed Practical Nurse (LPN) P was observed preparing medication at a medication cart. LPN E was asked if R701 was in isolation and what type of precautions. LPN E said, (R701) was on quarantine for 14 days,since they came from the hospital. On 8/5/2020 at 9:39 AM, the Administrator was interviewed and queried about the signage of isolation and the STOP sign for R701. The Administrator said, Oh, (R701) is not on any precautions. All of our quarantine residents are on the second floor. At that time the Administrator ripped the STOP sign off the laptop bracket. The Administrator was informed that LPN B stated that R701 was on COVID precautions due to hospital transfer. The Administrator stated, No, they don't know. That nurse is from the agency. (R701) is not on precautions. A review of R701's medical record noted admission to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of R701's care plan dated 8/5/2020 noted, Verify that proper isolation notifications are in place and appropriate protective equipment inside and outside room and follow facility policy for {Specify} Contact /Droplet Isolation. A review of the Care Plan noted that the Droplet Isolation was entered after speaking with the Administrator, and 4 days after the the resident was admitted into the facility. On 8/5/2020 at 9:55 AM, Nurse Manager B was observed at R701's door, placing signage for Droplet Precaution. Nurse Manager B was asked why there was not notification of Droplet Precaution prior to 8/5/2020 and not on 8/1/2020 when R701was admitted to the facility. Nurse Manager B said, (701's) on Droplet Precautions. The signs must have fallen off due to the humidity. There are not any (same sex) beds upstairs so we had to admit (R701) on this unit. A review of the second floor noted at least five empty rooms that were clean, with beds. On 8/5/2020 at 10:15 AM, a review of the medical record noted the order for Droplet Precautions was entered dated 8/5/2020 at 8:39 AM. The Administrator and Nurse Manager B were questioned regarding Droplet Precautions, and why the care plan didn't note precautions prior to 8/5/2020. The Administrator said, Well, the sign fell off the door. It was obvious that (R701) was in isolation because you told me that the sign was turned in the wrong direction. The Administrator was queried if signage for precautions should be at the room entrance. The Administrator said, Yes, but everyone knew (R701) was on precaution. The Administrator was queried why they took the STOP sign down and stated that R701 was not on isolation. The Administrator said, I said you are right. The sign should have been at the door. We should have placed (R701) upstairs but we thought (resident was not of the same sex of available beds). The Nurse Manager was queried why the order for Droplet Precaution was not entered upon admission. The Nurse Manager stated, It should have been entered at admission. A review of the facility's Infection Prevention and Control Interim Guideline for Suspected or Confirmed Coronavirus (COVID-19) noted the following: The facility will admit residents from hospitals where a case of COVID-19 was/is present. If possible dedicate a unit/wing for any residents admitted or readmitted from the hospital. The resident remain on the wing for 14 days with no symptoms .Post signs on the door or wall outside of the resident room to clearly describe the type of precaution needed and require PPE (Personal Protective Equipment).
F 0925 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an effective pest control program as evidenced by ants in the room of one sampled resident, R701, resulting in the potential for the transfer of disease, and the dissatisfaction with their living conditions at the facility. Findings Include: On 8/5/2020 at 9:00 AM, a tour of Unit One North was conducted. R701 was observed in their room sitting in a wheelchair. R701 stated, They have an ant problem here. Look behind my wheelchair. I noticed this when I got here. Observed several dozen live ants next to R701's bed. On 8/5/2020 at 9:39 AM, the Administrator was interviewed and queried about pest control on unit One North. The Administrator stated, I didn't know that there was a pest issue. The Administrator was escorted to R701's room. The Administrator said, (R701) probably brought the ants when they moved to this facility. R701 said, I did not bring any ants with me. The Administrator said, There's a lot of food on the floor. That's why there are ants. There are potato chips and peanut butter on the floor. R701 stated, I had chips with my meal yesterday, but the ants were there when I came to this room. On 8/5/2020 at 11:00 AM, the Maintenance Director F was interviewed about pest control, and stated, We have not had an issue with ants. A review of the facility's Pest Control Summary Report revealed that treatment for [REDACTED]. A review of the facility's Quality of Life -Homelike Environment policy noted the following: Residents are provided with a safe, clean, comfortable and homelike environment.

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