STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235182	A. BUILDING _____ B. WING _____	08/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LYNWOOD MANOR HEALTHCARE CENTER	730 KIMOLE LN ADRIAN, MI 49221

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 -** 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 follow and implement infection control practices per the Centers for Disease Control (CDC) guidelines to prevent the spread of COVID-19 including, but not limited to, 1) the failure to ensure that certain residents were cohorted after testing negative for COVID-19, 2) the failure to immediately isolate and segregate residents who tested positive for the COVID-19 virus including door closure of Covid positive room and eliminating oscillating fan use in droplet isolation rooms, 3) the failure to clearly post isolation signage, 4) the failure to perform proper hand hygiene, 5) the failure to ensure appropriate Personal Protective Equipment (PPE) utilization, supply, and care including use of cloth masks, 6) the failure to place residents who leave for appointment on observation unit, and 8) the failure to develop and operationalize policies and procedures related to COVID-19. These deficient practices resulted in Immediate Jeopardy when on 8/6/20 two facility residents with reported positive COVID-19 test results (Resident #1 and #3), with the likelihood for further cross contamination of other residents residing in the facility, thereby putting all 69 facility residents at risk for infection, hospitalization and/or death. Findings Include: On March 9th, 2020 the Centers for Medicare and Medicaid Service and the Centers for Disease Control and Prevention released guidance for Long Term Care facilities related to prevention and management of COVID-19 to protect their residents and staff from being affected by the deadly virus. Since that release the CDC has made changes to their recommendations for management of COVID-19 as more has been learned and as the pandemic evolved. HCP (healthcare personnel) should wear a facemask at all times while they are in the facility. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Guidance on extended use and reuse of facemasks is available. Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if PPE is required. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Flong-term-care-strategies.html) Resident with new-onset suspected or confirmed COVID-19 Ensure the resident is isolated and cared for using all recommended COVID-19 PPE. Place the resident in a single room if possible pending results of [DIAGNOSES REDACTED]-CoV-2 testing. Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents (e.g., residents who have fever, for example, due to a non-COVID-19 illness could be put at risk if moved to a COVID-19 unit). If cohorting symptomatic residents, care should be taken to ensure infection prevention and control interventions are in place to decrease the risk of cross-transmission. If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit. Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for [DIAGNOSES REDACTED]-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit). Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html) When undertaking facility-wide [MEDICAL CONDITION] testing, facility leadership should expect to identify multiple asymptomatic and pre-symptomatic residents with [DIAGNOSES REDACTED]-CoV-2 infection and be prepared to cohort residents. See Public Health Response to COVID-19 in Nursing Homes for more details. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html) HCP working in facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic or pre-symptomatic patients with [DIAGNOSES REDACTED]-CoV-2 infection. If [DIAGNOSES REDACTED]-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis). They should also: ?Wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions during patient care encounters .If admitted , place a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection in a single-person room with the door closed. The patient should have a dedicated bathroom .Personnel entering the room should use PPE as described below. As a measure to limit HCP exposure and conserve PPE, facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection. Dedicated means that HCP are assigned to care only for these patients during their shift .HCP who enter the room of a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator (or facemask if a respirator is not available), gown, gloves, and eye protection .HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html) During an observation and interview on 8/6/20 at 9:15 a.m., upon entering the facility for an infection control survey, the Administrator (NHA) A and Director of Nursing (DON) B met surveyors at the facility front door and reported they had just been notified of two positive COVID-19 test results from 8/3/20 for residents that had been asymptomatic and were roommates. NHA A reported the weekly resident testing was performed because the facility had two staff who tested positive for COVID-19 over the past couple weeks. DON B reported she was concerned about false positive COVID-19 test results because residents had no symptoms. This surveyor was escorted down A South hall and noted a three drawer cart located in front of one room. The resident room had an open door with an oscillating fan noted functioning and on with three resident names (R1, R2, R3) noted on the name plate outside the door. No isolation signage was observed clearly posted. Staff were noted in halls with cloth masks. In an interview on 8/6/20 at 9:33 AM, Director of Nursing (DON) B reported the two COVID positive residents were Resident #1 (R1) and Resident #3 (R3). When asked if there was a third resident in the room, DON B reported Resident #2 (R2) was negative for COVID-19 and still remained in the room with R1 and R3. When asked why R2 was still in the room with COVID positive residents, DON B sated Because he (R2) is in isolation. Everyone is asymptomatic. When asked what PPE should be used in the room, DON B reported shield, mask, gown, and gloves. When asked what type of mask, DON B stated If we have N95 masks, we would use them, but right now we only have surgical masks. N95s are hard to come by. When asked what type of mask should be worn in the facility, DON B reported surgical masks. During an observation on 8/6/20 at 9:40 a.m. three residents were noted in a room that appeared to be a three bed ward with three drawer cart located outside open door with box of gloves noted in cart. The oscillating fan continued to be functioning and on inside the room. A large industrial floor fan was observed outside of the room. Review of the medical record revealed R1 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set ((MDS) dated [DATE] revealed R1 scored 10 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS). Review of R1's laboratory results revealed R1 was tested for COVID-19 on 8/3/20 and positive results were reported on 8/6/20. Review of the medical record revealed R2 was admitted to the facility on

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 -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The MDS dated [DATE] revealed R2 scored 15 out of 15 (cognitively intact) on the BIMS. Review of R2's laboratory results revealed R2 was tested for COVID-19 on 8/3/20 and negative results were reported on 8/6/20. Review of the medical record revealed R3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of R3's laboratory results revealed R3 was tested for COVID-19 on 8/3/20 and positive results were reported on 8/6/20. According to observations and the medical records, R1, R2, and R3 shared a room. On 8/6/20 at 9:49 AM, R2 was observed in a room with R1 and R3. There was a PPE cart outside the room, but there was not any signage alerting staff to any precautions. R1 was not wearing a mask and was up, ambulating in the room. R3 was lying in bed. R2 was wearing a mask and was observed on the floor, waving and calling for help. The call light was on. The oscillating fan was located against the wall, across from the foot of R1's bed. The fan was oscillating and blowing towards all three residents in the room. A housekeeper on the hallway was observed wearing a cloth mask and a face shield. At 9:54 AM, Certified Nursing Assistant (CNA) H answered the call light wearing only a cloth face mask and a face shield. CNA H did not put on a gown or gloves before entering the room. CNA G then came out of the room, did not perform hand hygiene, touched the telephone on the hallway wall, and then exited the unit. At 9:55 AM, CNA H entered the unit, did not perform hand hygiene, again entered R1, R2, and R3's room without a gown or gloves and then exited the room and obtained a gown. At 9:56 AM, the nurse entered the room without a gown or gloves. The nurse touched the door handle, dropped her pen light on the floor twice, picked up the pen light, and set it on top of the PPE cart outside the room. The nurse was unable to find another gown in the PPE cart and then exited the hall. The nurse did not perform hand hygiene. CNA H then entered the room wearing a cloth face mask, face shield, gown, and gloves and approached R2. CNA H touched the privacy curtain, bedside table, and obtained a gait belt from inside the room. At 9:59 AM, falling star was paged overhead. Another staff member arrived, knocked on the door, and opened the door. The unidentified staff member was wearing a cloth face mask and a face shield. The nurse arrived back to the unit with more gowns, donned a gown, and entered the room with a cloth face mask, face shield, gown, and gloves. The nurse did not disinfect the pen light which had fallen on the floor twice previously nor perform hand hygiene. At 10:00 AM, a second nurse arrived to the unit with a sterile isolation gown kit. This nurse was wearing a surgical mask and a face shield. At 10:03 AM, NHA A arrived onto the unit and removed the large industrial fan from the hallway. NHA A reported the facility's air conditioning was not functioning properly and the fan was used, but a new unit was installed on 8/5/20 and the fan was no longer needed. At 10:08 AM, Central Supply staff K and Activities Manager L arrived to the unit with a cart of supplies to stock the PPE cart. When staff exited the residents' room, none of the staff were observed disinfecting their face shields. During an interview on 8/6/20 at 10:38 a.m. DON B reported she received positive COVID-19 test results that morning at approximately 6:30 or 7:00 AM and notified the local health department via email as well as the corporate office. DON B reported she placed room R1, R2, and R3's shared room in isolation, informed staff including environmental services and kitchen staff who plan to provide paper products for two of three residents in the room. DON B reported R1 and R3 that tested positive for COVID-19 that day were the first two asymptomatic residents and they placed residents on isolation for 14 days. DON B reported symptomatic residents would be sent to the hospital. DON B reported the facility had three residents that leave the facility for [MEDICAL TREATMENT] and wear masks when out of rooms and return to same rooms occupied by other residents that do not leave the facility for appointments. When asked how staff knew which mask to wear, DON B reported she was told by local Health Department that staff can use any type of mask and stated they never specified. DON B reported the facility had no access to N95 masks. When asked about the facility's plan for R1, R2, and R3, DON B stated if they remain aysymptomatic for 14 days and have two negative tests, then off isolation. When asked about the plan if the facility acquired additional positive COVID -19 test results with the next weekly testing, DON B stated Notify health department .If it's a resident, their room will be isolated just like this one (R1, R2, R3) here. If no symptoms, they can't go to the emergency room . During an observation on 8/6/20 at 12:08 p.m., staff were observed on COVID-19 observation unit wearing cloth masks and face shields. During an observation on 8/6/20 at 12:48 p.m., Certified Nurse Aid (CNA) entered the open door of R1, R2, and R3's room (isolation room) with Personal Protective Equipment (PPE) that included face shield, cloth mask, disposable gown, and gloves. CNA staff obtained food tray from inside isolation room that included hard plastic tray, Styrofoam food container, clear plastic cups and placed on top of the isolation cart located in the hall. After CNA staff removed PPE she then moved the meal tray located on top of the isolation cart and placed in meal cart located in the hall. The same CNA staff then entered isolation room immediately after with no PPE and exited with meal tray and placed in meal cart that included Styrofoam food container, plastic tray and cups. This surveyor noted at same time another staff member entered A South hall with another meal cart from the front lobby through A South hall toward the Main Dinning Room doors. During a telephone interview on 8/7/20 at 11:25 a.m. CNA G reported all staff enter through front door and complete screening process including temperature and log at start of shift and not at end of shift. CNA G reported he often worked on observation unit that included new admission residents that remained on isolation for 14 days. CNA G reported DON B informed staff 8/6/20 at about 7:00 AM about two positive COVID-19 residents in the building. CNA G reported he placed an isolation cart in front of R1, R2, and R3's shared room on the morning of 8/6/20 and did not verify if the cart was stocked and reported another staff member was responsible for stocking isolation carts. CNA G reported he received education on 8/6/20 related to use of N95 masks and shield at all times in the facility. CNA G reported education included to use N95 masks for 48 to 72 hours. CNA G reported staff had recently worked on several halls between 8/3/20 and 8/6/20. CNA G reported he had not received education related to ensuring COVID-19 room doors remained closed. CNA G reported meal trays were served with Styrofoam food containers but real plastic tray and stated, now that I think about that hmmm, should all be disposable. CNA G reported the observation unit used regular meal trays. CNA G reported he was given N95 mask 8/6/20 after lunch and observed large box of stock available for use. During a telephone interview on 8/7/20 at 2:39 p.m. Dietary Aid (DA) J, reported working at the facility for [AGE] years. DA J reported staff could wear cloth masks until 8/6/20 about lunch time then changed to N95 and face shields. DA J reported 8/6/20, the entire A South unit used Styrofoam, plastic silverware, Styrofoam cups and regular glasses because no small glasses for juice were available and reported the observation hall had been and continued to receive regular trays, plates and glasses. DA J reported she was unsure why the manager started Styrofoam for A south other than she was told to because of 2 COVID-19 cases. DA J reported she was unsure why they use Styrofoam other than in the past it was used for isolation rooms but unsure why. DA J reported Styrofoam food containers are returned in the meal carts and disposed of in the kitchen. Review of a chain of emails between the facility and the local Health Department, revealed the following: -On 5/16/20, the local health department sent the facility three CDC links regarding PPE, including eye protection and respirators and one link for FEMA - On 5/24/20, the local health department sent the facility an email with information regarding the National Guard performing COVID testing and stated While we fully support testing of all residents and staff, it is critical that you have a plan in place that addresses the following before you move forward with testing: A plan to isolate a resident who tests positive Do you have sufficient staff so that staff attending to any positive residents are also not attending to non-positive residents . - On 6/2/20, the local health department sent the facility information on PPE purchasing and N95 fit testing - On 8/6/20 at 9:54 AM, the local health department sent an email to DON B that read It was my undertanding from our phone conversation this morning that all HCP staff have been wearing surgical masks and face shields prior to today. If for some reason that has not been the standard for all HCP (see definition below (CDC definition) employees providing any resident care or who will be within 6 feet of any resident then it needs to be adopted immediately. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html which I emailed to you on 7/16/20. This is the part that speaks to the eye protection .Also, this morning you said that residents can go outside to smoke-I was not aware that this was allowed. Smoking would be a high-risk activity for the spread of COVID. - On 8/7/20 the local health department sent an email to NHA A which revealed .(DON B) said the two positive residents smoke outside-we had discussed and I also emailed my recommendations re: the smoking and (DON B) said it had been halted . On 8/6/20 at 12:05 PM, the Administrator was notified of the Immediate Jeopardy that began on 8/6/20 and was identified on 8/6/20, when the facility failed to follow and implement infection control practices per the Centers for Disease Control (CDC) guidelines to prevent the spread of Covid-19. On 8/7/20 it was verified that the facility implemented the following to remove the Immediate Jeopardy: 1. Resident # 2 with negative COVID test has been moved to private room on the observation unit, isolation signage placed on room door, with door closed due to possible exposure to COVID-19. Oscillating fan removed, door closed, isolation signage placed for room which houses resident # 1 and resident #3. Isolation carts with PPE placed outside of room [ROOM NUMBER] and room [ROOM NUMBER]. Staff provided isolation gowns, N95 masks, and face shields for use when caring for these residents. Isolation signage was posted on observation and isolation rooms and to remain at all times. Residents who leave for appointments will be placed on the observation unit upon return.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) [MEDICAL TREATMENT] residents have been cohorted with other [MEDICAL TREATMENT] residents and placed in isolation. Oscilating fan was disinfected and removed from (resident room #). 2. DON or Designee has educated staff on the use of PPE, to include gloves, gown, N95 mask, and face shield when caring for any COVID positive resident and for any resident in observation for COVID-19 on 8/6/20. DON or Designee has educated all staff on proper hand hygiene, face shield disinfecting, gloves and N95 masks donning and doffing of PPE on 8/6/20. DON or designee will educate remaining staff prior to assignment. DON or Designee has educated all staff on resident co hoarding per CDC guidelines on 8/6/20. DON or Designee has educated all staff that any resident that leaves the facility for a medical appointment must be placed in the observation area for 14 days on 8/6/20. DON or Designee will educate staff that there can not be any oscillating fans in COVID positive rooms due to potential spread of [MEDICAL CONDITION] on 8/6/20. 3. If a resident tests positive for COVID-19 and has signs and symptoms they will be sent to the ER for treatment. If they are asymptomatic, they will be put in isolation with themselves or another positive COVID 19 patient on A south hall. A south hall will be considered under investigation. Should we have more Covid positive residents they will be put in a separate area on A south separated from other A south residents. Although the Immediate Jeopardy was removed on 8/6/20, the facility remained out of compliance at a scope of isolated and a severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy due to the fact that sustained compliance had not yet been verified by the State Agency.