STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235428	A. BUILDING _____ B. WING _____	05/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-DEARBORN HEIGHTS	26001 FORD RD DEARBORN HEIGHTS, MI 48127

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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, during a Covid-19 Focused Survey, the facility failed to implement and maintain infection control practices in the dedicated Covid-19 unit of the facility resulting in lack of utilization of Personal Protection Equipment (PPE) for Resident #701, lack of hand hygiene performance, and the potential spread of infectious organisms to all 29 Residents residing in the dedicated Covid-19 unit. Findings include: An interview was conducted with Registered Nurse (RN) Unit Manager C on 5/19/20 at 9:35 AM. When queried regarding Covid-19 within the facility, RN Unit Manager C revealed all Covid positive Residents are placed in a dedicated unit of the facility. When asked how many Residents were positive for Covid-19, RN Unit Manager C indicated they thought 30. When asked, RN Unit Manager C revealed newly admitted Residents were placed in various rooms throughout the facility and not in the dedicated Covid-19 Unit. A tour of the dedicated Covid-19 Unit in the facility began on 5/19/20 at 10:05 AM. Upon entering the unit, Resident #701 was observed being pushed down the hall by Nursing Assistant D. Resident #701 was not wearing a mask and/or face covering and was coughing. Licensed Practical Nurse (LPN) B was also noted in the hall. Upon approaching Nursing Assistant D and Resident #701, Nursing Assistant D was noted to not be wearing gloves while pushing the Resident in the wheelchair. At this time, LPN B stopped Nursing Assistant D and the staff member proceeded to turn and push the Resident back to their room. Nursing Assistant D returned to Resident #701's room, obtained a procedural mask from the room and proceeded to place the mask over Resident #701's face without wearing gloves. Nursing Assistant D did not perform hand hygiene. An interview was attempted to be completed with the Resident from the doorway of their room. When spoke to, the Resident made eye contact but did not respond. When asked, Nursing Assistant D revealed Resident #701 did not always respond when spoke to. Nursing Assistant D then propelled the Resident out of the room, in the wheelchair, down the hall. When queried, Nursing Assistant D indicated Resident #701 was leaving the facility to receive their [MEDICAL TREATMENT] treatment. When Nursing Assistant D and Resident #701 arrived to the nurses' station, LPN B stopped them and proceeded to open and begin looking through the green colored cloth bag hanging on the back of the Resident's wheelchair without wearing gloves. LPN B then entered the Clean Utility Room, with a touch pad code, obtained oxygen tubing, and exited the Clean Utility room without wearing gloves and/or performing hand hygiene. LPN B did not disinfect the touch pad code. LPN B then touched items and the portable oxygen tank on the Resident's wheelchair. At this time, LPN B and Nursing Assistant D returned the Resident to their room, towards the end of the hall, and applied the supplemental oxygen via nasal cannula. LPN B performed hand hygiene in the Resident's room bathroom after applying the oxygen. After Resident #701's oxygen tubing was in place, Nursing Assistant D proceeded to push the Resident through the unit in their wheelchair, to an outside exit door without wearing gloves. Resident #701 continued to cough while being transported throughout the unit. Upon approaching the exit door, Nursing Assistant D entered a code, on a touch pad on the wall and opened the door to an area where transportation service staff were waiting to take Resident #701 to [MEDICAL TREATMENT]. Nursing Assistant D did not perform hand hygiene and did not disinfect the exit code touch pad. An interview was completed with Nursing Assistant D on 5/19/20 at 10:15 AM. When asked if other Residents on the Covid Unit leave regularly for medical care/treatments, Nursing Assistant D stated, No, (Resident #701) is the only one. When queried regarding facility policy/procedure pertaining to Residents wearing masks when out of their rooms in the Covid unit, glove use, and hand hygiene, Nursing Assistant D did not provide a response. Hand sanitizer wall hanging dispensers within the Covid-19 unit were noted to be empty on 5/19/20 at 10:16 AM. On 5/19/20 at 10:20 AM, Nursing Assistant E was observed exiting a Resident room in the Covid-19 Unit and attempting, without success, to obtain hand sanitizer from a hanging hand sanitizer wall dispenser unit. Nursing Assistant E was observed wearing a droplet procedural mask under an N95 mask (respirator mask that is worn snuggly to the face to filter 95% of 0.3 microns sized airborne particles). An interview was conducted with Nursing Assistant E at this time. When asked about the hand sanitizer dispensers being empty, Nursing Assistant E indicated they would need to wash their hands in the staff bathroom. When queried regarding wearing a droplet procedural mask under their N95 mask, Nursing Assistant E revealed the N95 bothered their face, so they wear the other mask under it because it is softer. When queried regarding facility provided education regarding N95 mask fit, including the need to form a seal to provide protection, Nursing Assistant E revealed they were unaware that N95 masks needed to form a tight seal to the face for filtration. A tour of the Covid-19 unit at 10:25 AM on 5/19/20 revealed only one occupied Resident room door was closed, nine rooms were shared by two Residents, and nine rooms were empty. The privacy curtains in the rooms with two Residents were not pulled. At 10:30 AM on 5/19/20, Nursing Assistant D was observed in a Resident's room, touching the Resident's bed, without wearing gloves. Upon speaking to Nursing Assistant D from the doorway of the room, Nursing Assistant D donned gloves. At this time, another Nursing Assistant was observed calling for Nursing Assistant D's assistance in a different Resident room in the hall. Nursing Assistant D was observed removing their gloves, exiting the room, and entering the other Resident's room without performing hand hygiene. On 5/19/20 at 10:36 AM, Nursing Assistant G was observed sitting at a computer workstation at the nurses' station. Nursing Assistant G was wearing an N95 mask, goggles, and gown. Nursing Assistant G did not have gloves on, and their bare hand was resting directly on their cheek and the outside of the N95 mask. At 10:45 AM on 5/19/20, Nursing Assistant G and Nursing Assistant F were sitting at the nurses' station and an interview was conducted. When asked if they were supposed to touch the outside of their mask, per facility policy/procedure, Nursing Assistant G replied, No. When queried regarding facility policy/procedure related to glove use and hand hygiene in the Covid-19 unit of the facility, Nursing Assistant G replied, Wear when go in room. When asked if gloves are donned prior to entering a Resident room, Nursing Assistant G stated, No, have to wait until in (the Resident room). With further inquiry regarding facility expectation regarding glove use, Nursing Assistant G stated, Supposed to go in (room), wash hands in Resident bathroom. When queried if the Residents are using the bathroom and sink in their rooms, Nursing Assistant G replied, Yeah. When asked about the location of gloves in Resident rooms, Nursing Assistant F indicated gloves are in different places within the rooms. When queried if gloves are located next to the entrance door of the room, Nursing Assistant F revealed gloves are frequently located in the middle of the room on the wall. An interview was completed with LPN A on 5/19/20 at 11:00 AM. When queried regarding facility policy/procedure pertaining to utilization of masks and/or face coverings for Residents with Covid-19 when they are out of their rooms, LPN A replied, We kind of like them to stay in their rooms. When asked if Residents who are positive for Covid-19 and leave the facility for medical reasons including [MEDICAL TREATMENT] are supposed to wear masks, LPN A stated, Yeah. When queried regarding facility policy/procedure pertaining to Resident room doors being open with positive Covid-19 infection, LPN A stated, Open. LPN A further revealed staff close the door or shut the room curtain when Residents receive breathing treatments. When asked how many Residents receive breathing treatments on the Covid-19 unit, LPN A replied, Two. When queried if Resident room divider/privacy curtains should be closed between Residents when there are two Residents in a room, LPN A stated, No. LPN A was then queried regarding glove use and hand

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) hygiene in the Covid-19 unit and replied, We are supposed to have them (gloves) on all the time. When asked if they are supposed to wear gloves in the hall of the facility, LPN A revealed they were. On 5/19/20 at 11:05 AM, an interview was conducted with LPN B. When queried regarding facility policy/procedure pertaining to PPE and glove use as well as hand hygiene, LPN B stated, Only wear when go in a room. When queried regarding observation of them touching Resident #701, their wheelchair/belongings without gloves and then entering the Clean Utility room without performing hand hygiene and/or donning gloves, LPN B replied, I was in a hurry. No further explanation was provided. Record review of Resident #701's medical record revealed the Resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #701 was severely cognitively impaired and required extensive assistance to perform Activities of Daily Living (ADLs). Review of Resident #701's progress note documentation in the medical record revealed the Resident was tested for Covid-19 on 4/20/20, transferred to the hospital on [DATE] due to a change in condition, and readmitted on [DATE] with confirmed positive Covid-19. An interview was conducted with the Director of Nursing (DON) and facility Administrator on 5/20/20 at 8:40 AM. When queried regarding what PPE staff are supposed to wear in the dedicated Covid-19 unit of the facility, the DON stated, Eye protection, gown, gloves, and N95 mask. When queried regarding facility policy/procedure pertaining to PPE for Residents outside of their rooms and/or leaving the facility who are in the Covid-19 unit of the facility, the DON replied, Residents are supposed to leave with an N95. The Administrator and DON further stated, If just in the hall, Residents do not need any mask. When queried regarding staff use of PPE and gloves in the dedicated Covid-19 unit, the DON replied, Staff enter the unit with clean gloves. They take gloves off, put on new (gloves), and perform hand hygiene when give care. When queried where staff are supposed to perform hand hygiene and don new gloves, the DON and Administrator indicated staff are able to use the sink in Resident's bathrooms. When asked if the Residents also use the sinks in their bathrooms, the DON replied, Yes, I'm sure a few are. When queried how staff are donning all PPE, including gloves, prior to entering a positive Covid-19 Residents room when they are washing their hands in Resident bathroom sinks, located at the back of the Resident room, the DON and Administrator did not provide an explanation. When queried regarding empty hand sanitizer dispensers in the Covid-19 unit hall and gloves not being positioned outside of or near the entrance of Resident rooms, the DON indicated gloves are available on the nurse medication carts. The Administrator further indicated the hand sanitizer dispensers shshould not be empty. When asked if staff ould always wear clean gloves in the hall of the Covid-19 unit, the DON stated, Yes. When queried regarding facility policy/procedure pertaining to Resident room doors being open and privacy curtains not closed in shared rooms in the Covid-19 unit, the Administrator stated, We got the okay to have the doors open. The DON elaborated that the room door is closed during breathing treatments. When queried regarding observations of Nurse B and Nursing Assistant D with Resident #701 in the hall of the facility, including the Resident not wearing a mask and coughing, lack of glove use and hand hygiene by Nurse B and Nursing Assistant D, and contamination of items in the Clean Utility room, the DON revealed appropriate precautions were not followed and indicated they would re-educate staff. A policy/procedure pertaining to movement and transportation of Residents in the Covid-19 unit was requested at this time. Review of facility provided policy/procedure entitled, Covid-19 Clinical Monitoring and Measures Plan (Updated: 5/18/20) revealed, Tier Three . Activation of Covid-19 Airborne Isolation Unit . Dedicated stock and supplies (goggles, gowns, N-95 masks . The provided policy/procedure did not address room doors being open, hand hygiene availability, Resident movement outside of the room/unit, and/or Resident use of face masks. Review of facility provided policy entitled, Chapter 2: Practice Guidelines (2013) revealed, Airborne Precautions . Patient Transport . Limit patient transport; if transport necessary, patient wears a surgical mask . Review of facility provided procedure entitled, Covid-19 Focused Survey Rounds Tool (Dated 5/7/20) revealed gloves should be changed and hand hygiene performed prior to moving from dirty to clean area and Residents must wear a mask if they leave the facility.