STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235477	A. BUILDING _____ B. WING _____	09/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
POMEROY LIVING ROCHESTER SKILLED REHABILITATION	**3500 WEST SOUTH BLVD ROCHESTER HILLS, MI 48309**

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 implement an appropriate 14-day COVID-19 isolation program for residents admitting to the facility or returning from outside appointments for two residents (R#'s 603 and 606) of six residents reviewed for infection control, resulting in verbalized feelings of frustration and the potential for the spread of infections including COVID-19. Findings include: On 9/2/20 at approximately 9:00 AM, an observation of the facility layout was conducted and revealed a front lobby area with a locked sliding door. Beyond the sliding door, immediately to the left there was a locked double door leading to the Bradford Unit, the facility's designated COVID-19 unit. Further up the hallway on the right hand side were non-resident care areas consisting of conference rooms, a resident store, a beauty shop, and a theater. Diagonally across the hall to the left of the theater was a bistro, and up the hallway to the right of the theater was a set of closed double doors that entered into the Auburn Unit, the facility's Transitional Unit. Outside of the bistro was a seating area with chairs and a small table. On 9/2/20 at approximately 11:00 AM an interview with the facility's Director of Clinical Services/Acting Director of Nursing (DON) was conducted regarding the facility's layout and unit designations. The acting DON indicated the Bradford Unit had only residents that were positive for COVID-19 and the Auburn Unit was their Transitional Unit. When asked what was meant by Transitional Unit The acting DON indicated the Bradford Unit had residents who were newly admitted , readmitted , had been out in the community, or on a leave of absence. The DON further explained that residents who went out for [MEDICAL TREATMENT] were also on the unit because they went out into the community for their [MEDICAL TREATMENT] appointments. The DON continued to explain that residents on the Bradford Unit were placed on Observational Precautions. When asked to explain what Observational Precautions were, the DON explained the residents were being monitored for any respiratory or COVID-19 symptoms for 14 days after their admission. The DON was then asked what type of personal protective equipment (PPE) was used for Observational Precautions on the Auburn unit, and indicated staff would wear a N95 face mask, a face shield, an isolation gown, and gloves. When queried how the PPE requirements differed from that of droplet precautions, the DON indicated they were the same. On 9/2/20 at 2:30 PM, an observation of the Auburn unit was conducted. The individual room doors had neon green signs on them that read, Observation room [ROOM NUMBER] Day Quarantine Please follow the guidelines below: Resident is to remain in room unless medically necessary. Door should remain shut as safe and appropriate. Dedicated equipment when possible. Clean and disinfect shared equipment. Face shield, KN95 mask and gloves are required when entering room. During the observation, at approximately 2:35 PM, Staff Member 'D' was observed in the doorway of R603's room. R603 was heard anxiously asking why their room door had to be closed. R603 continued to escalate their voice volume to Staff Member 'D' angrily saying they did not want their door closed and they did not understand why Staff Member 'D' was trying to close the door. Staff Member 'D' attempted to explain the rationale for closing the door, but R603 continued to object. R603 was becoming more distressed and was overheard pleading, Please don't shut my door, it's my only way to the outside world. At approximately 2:40 PM, an interview was conducted with Licensed Practical Nurse (LPN) 'B', (a nurse assigned to the unit) regarding the resident's on the Auburn Unit. LPN 'B' was asked if all of the resident's on the unit were in 14-day quarantine as indicated by the green signs and said they were. At that time, Unit Manager 'A' overheard LPN 'B' and corrected her, saying that not all residents on the unit were on 14-day quarantine. LPN 'B' said, I didn't know that. Unit Manager 'A' was asked which resident's were not on 14-day quarantine and was staff supposed to wear the full PPE (Mask, gown, shield, gloves) for the residents that she said were not on quarantine. At that time, Unit Manager 'A' indicated that even though some resident's were not on 14 day quarantine, because they had rooms on that unit, the staff still wore full PPE. Unit Manager 'A' stated, We treat everyone the same. At approximately 2:50 PM, an interview with Certified Nursing Assistant (CNA) 'C', who was working on the Auburn Unit was conducted. CNA 'C' was asked if all residents on the unit were on 14-day quarantine and indicated they were. When asked about PPE usage, CNA 'C' indicated they were to wear a face mask, shield, gown, and gloves when entering all rooms on the unit. On 9/2/20 at approximately 10:30 AM, R606 was observed wandering around the non-resident care area hallway in proximity to to the theater and the bistro. On 9/2/20 at approximately 2:55 PM, an interview with the facility's Administrator was conducted regarding the Auburn Unit. The Administrator was asked what resident's were assigned to the Auburn unit and said, Specifically, two classes of residents were on the Auburn unit. When asked what was meant by two classes the Administrator indicated there were short-term rehab residents and residents in quarantine. When asked about the use of PPE and the treatment of [REDACTED]. When asked about the difference between resident's in quarantine and residents who were not in quarantine the Administrator explained that if resident's weren't in quarantine they could have their doors open and they could come out of their rooms. The Administrator was asked specifically about R603 (who had been observed exhibiting some anger and anxiety regarding their room door being closed) and why they were still being treated as a 14-day quarantine resident when they had been at the facility for more than 14 days, and additionally had tested negative for COVID-19 on 8/31/20. The Administrator deferred the question to the DON and Unit Manager. On 9/2/20 at approximately 3:00 PM, a follow-up interview with the facility's DON was conducted regarding R603. The DON explained that because R603 was receiving short term rehab they were kept on the Auburn Unit. When queried why R603 could not come off 14-day quarantine, the DON said that because R606 (a [MEDICAL TREATMENT] resident who left for [MEDICAL TREATMENT] appointments three times a week) resided on that unit and wandered throughout the unit, he continued to put everyone else at risk, so no one on the Auburn unit could come off quarantine. When queried if R606 was re-directable to stay in their room, the DON indicated they were. At that time, it was brought to the DON's attention that R606 had been observed off the Auburn unit and wandering around the non-resident care area near the theater and the bistro. The DON indicated R606 should not have been able to leave the unit and staff should have been providing supervision. The DON was further queried why a portion of the Auburn unit could not be used for residents that were short-term rehab, but no longer required 14-day isolation. The DON indicated that was their plan for resident's who graduated from their 14-day quarantine, but it hadn't occurred yet, because the Auburn unit had only been their designated transitional unit since August 28th, when it switched from Bradford to Auburn. When queried why it wasn't done on August 28th when they designated Auburn as their transitional unit the DON said, We didn't have the man power. When queried if that was regards to nursing staff, the DON said, it wasn't, it was due to not enough housekeeping staff. A review of R603's clinical record was conducted and revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. R603's most recent Minimum Data Set (MDS) assessment dated [DATE] indicated R603 had moderately impaired cognition. A review of R603's physician's orders [REDACTED]. A review of a COVID-19 nasal swab ordered 8/29/20 and reported back to the facility on [DATE] indicated R603 was negative for COVID-19. A review of R606's clinical record was conducted and revealed a re-admission date of [DATE] with [DIAGNOSES REDACTED]. R606's most recent MDS assessment dated [DATE] indicated R606 had severe cognitive impairment, was independently ambulatory, and exhibited wandering behaviors. A review of R606's physician's orders [REDACTED]. A review of a facility provided document titled, COVID-19 Plan of Action with a revision date of 9/1/20 was reviewed, but did not address the facility's designation or usage of a Transitional Unit. A review of a

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) second facility provided document titled, New Admits/Resident Leaving the Building Protocol with a revision date of 8/28/20 was conducted and read, .Any resident leaving the facility for an appointment or [MEDICAL TREATMENT] and any resident being admitted or readmitted to the facility will be placed on transmission based precautions .for 14 days upon return to the facility .After 14 days of observation, the resident will be moved off the observation unit . The facility was asked if they had any additional information to provide regarding the concern; none was provided by the end of the survey.