STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235529	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE MANOR OF NOVI	24500 MEADOWBROOK RD NOVI, MI 48375

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to operationalize its policy to identify abuse, report allegations immediately to the Abuse Coordinator, State Agency, and/or local law enforcement, and protect a resident following abuse allegations and resident to resident incidents between two (R#803 and R#804) residents reviewed for abuse, resulting in delayed investigation and the increased potential for unidentified and/or continued abuse, Findings include: Resident #803 A review of the clinical record revealed R#803 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS) assessment dated [DATE], R#803 had moderately impaired cognition (scored 12/15 on mental status exam), had no hallucinations or delusions, had verbal behavioral symptoms directed towards others, rejection of care, and required extensive assistance with most aspects of care. Further review of the clinical records included the following documented entries: A progress note dated 5/11/20 at 9:28 PM authored by Registered Nurse (RN O) read, in part: Resident presents as agitated, anxious and delusional accusing roommate of trying to rape him. Res (Resident) states I have not slept for 3 days because of him. Writer observed res. sleeping with eyes closed last few nights. Res. refusing medications and sitting on edge of bed. Writer spoke with daughter regarding behaviors, daughter was able to calm res and res was compliant with med (medication) regimen . A progress note dated 5/16/20 at 3:33 PM authored by Licensed Practical Nurse (LPN M) read, in part: Res. arguing with room mate stating I'm going to F*** him up he said he was going to rape my daughter when she visit at the window. Roommate denies stating No I said I was going to f*** both y'all up but don't lie and say that. Writer explained to both res. to stay on their side of the room and don't talk to each other to defuse situation res agreed . There was no documentation that the facility's Abuse Coordinator (Administrator) had been notified of this allegation, any interventions to protect R#803 from R#804 following this allegation, or that an investigation had been initiated. Resident #804 A review of the clinical record revealed R#804 was initially admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the MDS assessment dated [DATE], R#804 had moderately impaired cognition (scored 12/15 on mental status exam), had no delusions, hallucinations or behaviors, and required supervision with setup for all aspects of care. Further review of the clinical record included the following entries: A progress note dated 5/11/20 at 2:36 PM read, in part: Res observed packing belongings when asked by writer where are you going res stated I'm moving out of here to a new apartments .Res observed talking to stuff <sic> animals calling them his kids . A progress note dated 5/11/20 at 9:24 PM read, in part: Resident alert with confusion. Res continues to focus on leaving and going to his apartment . A progress note dated 5/16/20 at 3:19 PM read, in part: Res in room observed arguing with roommate stating I will f*** you and your daughter up CNA entered room to defuse situation res stated You shut the f*** up talking to before I f*** you up CNA asked writer to try and get res to talk to res. Res stated to writer you don't have to come in here I don't want nobody telling me what to do he started with me 2 weeks ago now I'm the bad guy. Writer explained to both residents to stay on there <sic> side of room and do not communicate with each other . A progress note dated 5/17/20 at 4:07 PM read, in part: resident was talking very disrespectful told me to shut the f*** up. Wheres <sic> his tray, as I told him to go back into his room I took his roommate <sic> tray in (name of R#804) came in as I was leaving out he hit me in the back-Res states when asked by writer I didn't hit her I tapped her shoulder saying thank you for bringing my food tray. There was no documentation that the facility's Abuse Coordinator (Administrator) had been notified of this allegation, any interventions to protect R#803 from R#804 following this allegation, or that an investigation had been initiated. The most recent documented social service entry was 3/12/20. There was no evidence social services had been contacted regarding the resident to resident incident and allegation. On 5/18/20 at 12:22 PM, LPN M was contacted by phone and a return call was requested. There was no return call by the end of the survey. On 5/18/20 at 12:26 PM, a phone interview was conducted with RN O. When asked to explain the facility's process for reporting any abuse allegations, RN O reported, If any allegation, I'd be calling the DON, Administrator, my manager (Nurse Manager F). When asked if RN O had been aware of any recent abuse allegations, or resident to resident incidents, RN O stated, I'm not aware of any. At that time, RN O was asked about the documented entry from 5/11/20 at 9:28 PM and reported, I talked to his daughter. I know both residents very well. (Name of R#804) isn't like that. It's a highly situation where everyone is in quarantine. When asked if RN Os documentation of alleged rape was reported to anyone, RN O stated, I spoke with (Nurse Manager F) and said he was agitated. Said they weren't getting along. Shouldn't be together. When asked why the abuse allegation had not specifically been reported, RN O stated, Well, I let them know agitated .Because I know the resident and I didn't think it was abuse. On 5/18/20 at 1:00 PM, the Administrator was interviewed by phone. When asked if he had been aware of any recent abuse allegations as the Abuse Coordinator, the Administrator reported he was not aware of any. At that time, the Administrator was informed of the documented allegations from 5/11/20 and 5/16/20 and reported, Let me follow up on this now. On 5/18/20 at 6:25 PM, the DON was asked about the concern that RN O and LPN M had not reported allegations of abuse and/or resident to resident abuse and the DON reported the facility usually doesn't have problems like that, it was not put on an alert (electronically to be reviewed by the interdisciplinary team) and staff had not followed the facility's abuse policy. A review of the facility's policy titled, Abuse Prohibition Policy dated Revised: 07/2018 documented, in part: .Allegations of resident abuse .shall be thoroughly investigated and documented by the Administrator, and reported to the appropriate state agencies .Verbal Abuse is defined as the use of oral, written or gestured language that includes disparaging and derogatory terms to residents .or within their hearing distance, regardless of their age, ability to comprehend or disability .Sexual Abuse is non-consensual sexual contact of any type with a resident. Examples .A resident forcefully requires another resident to participate in a sexual act .Mental Abuse includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation. Examples .A combative resident threatens to beat up another resident .Allegations by anyone who becomes aware of verbal, physical, mental, sexual or emotional abuse and mistreatment .must immediately report it to his/her Administrator .The Director of Nursing or designee will complete an assessment of resident(s) and document finding sin the medical record .An Incident Report will be completed .If the incident .was a sexual assault, the resident will be transferred to a hospital emergency room .If possible rap has occurred: The hospital staff and law officers will determine if a rape examination should be conducted .The Administrator or Director of Nursing shall call local police when assault, sexual abuse .are suspected to have occurred or per state law .If the accused is a resident, the rights of the resident-at-large will be upheld via appropriate interventions as determined by the severity of the occurrence .When a resident displays behavior against another resident that is suspected abuse, the residents will be separated from each other .All allegations of abuse will be recorded on an Incident and Accident Report .
F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake # MI 273: Based on observation, interview and record review the facility failed to institute and operationalize appropriate infection control principles and practices per the Centers for Disease Control

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 -** Many	(continued... from page 1) Prevention (CDC) safety measures to prevent the exposure/transmission of residents to 2019 Novel Coronavirus (COVID-19) by: 1) ensure staff working on the designated COVID-19 containment unit donned new/sanitized PPE (Personal Protective Equipment) when caring for non-COVID positive residents that resided within that unit (R#s 806, 807, 808 and 813); and 2) consistently screen with verification for incoming staff/visitor temperatures and review of assessment questions/responses. The failure to follow current CDC recommendations for COVID-19 resulted in an Immediate Jeopardy (IJ) to the health and safety of all residents, many of whom were at high risk due to age and co-morbidities, to be exposed and/or develop COVID-19, given the high risk of spread once COVID-19 enters a nursing home, facilities must take immediate action to protect residents, families, and healthcare personnel (HCP) from resulting in serious health complications from COVID-19 hospitalization s, and death. Findings include: The IJ began on 4/23/20. The IJ was identified on 5/14/20. The Administrator was notified of the IJ on 5/14/20 at 4:45 PM and a plan to remove the immediacy was requested. Although the immediacy was removed on 5/18/20, the facility remained out of compliance at a scope of widespread and a severity of potential for more than minimal harm that is not Immediate Jeopardy due to sustained compliance that has not been verified by the State Agency. Review of a complaint filed with the State Agency on 5/13/20 included an allegation that the facility failed to follow current guidance related to infection prevention and control. On 5/13/20 at 5:50 PM, interview with the complainant by phone included concerns regarding the cohorting of and sharing bathrooms of positive and negative COVID-19 residents throughout the facility, and the lack of daily staff and/or visitor screening. An onsite investigation into the above complaint was conducted from 5/14/20 to 5/19/20. On 5/14/20 at 8:15 AM, the Administrator was queried about the facility's practices for placement of positive, presumptive, or negative COVID-19 residents. The Administrator reported the previously identified COVID-19 unit was the New admission/containment unit and further reported that residents that were admitted from the hospital were placed on that designated unit, even if negative for COVID-19 to monitor for 14 days. When asked if there were any other residents on isolation precautions throughout the facility, the Administrator reported there were. When asked why those residents on isolation were not placed onto the designated containment unit, the Administrator reported, If they were positive, we try not to move them. At that time, the Administrator was requested to provide a list of residents that were on isolation precautions, and to identify if any residents were positive for COVID-19. The Administrator reported there were four residents on the containment unit that were not positive, but being monitored due to recent hospitalization (R#s 806, 807, 808, and 813). Review of the documentation provided by the facility included lists of residents that identified 38 positive COVID-19 residents, and three presumptive positive residents. Resident #809, #810 & #811 A review of census records revealed R#809 shared/had access to an adjoining bathroom with R#811 from 2/15/20 to 5/17/20, and R#810 from 4/30/20 to 5/17/20. On 5/17/20, R#809 was moved to a different room on the same unit. A review of R#809's clinical record revealed R#809 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the physician orders [REDACTED]. As of 5/18/20, R#809 remained on contact and droplet isolation precautions. A review of R#810's clinical record revealed R#810 was admitted into the facility on [DATE] and readmitted to the facility's COVID-19/containment unit on 4/16/20 with [DIAGNOSES REDACTED]. A review of the census information revealed R#810 moved to the room shared with R#811 and adjoining bathroom with R#809 on 4/30/20. Review of the hospital discharge summary which read, .4/9/2020 .Molecular Infectious Diseases .COVID-19: DETECTED . Further review of the physician orders [REDACTED]. As of 5/18/20, R#810 remained on contact and droplet isolation precautions. There was no lab testing for COVID-19 conducted at the facility for R#810. A review of R#811's clinical record revealed R#811 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Further review of the physician orders [REDACTED]. A review of the census information revealed R#811 remained roommates with R#810 who had previously tested positive for COVID-19. There was no documentation that R#811 had any laboratory testing for COVID-19 ordered while at the facility. As of 5/18/20, R#811 remained roommates with R#810 and on contact and droplet isolation precautions. On 5/18/20 at 6:10 PM, observation of the hallway R#809, R#810 and R#811 resided revealed there were no posting of isolation precautions, or PPE available on the unit. On 5/18/20 at 6:13 PM, Licensed Practical Nurse (LPN Q) was queried about whether there any residents on contact or droplet isolation precautions and LPN Q stated, No one on isolation at this time. When asked about R#809, R#810 and R#811, LPN Q proceeded to open the door to the room shared by R#810 and R#811, entered without donning PPE and stated, Yes, they're in here. LPN Q further reported that R#809 was now in a different room in that hallway. On 5/18/20 at 6:25 PM, the Director of Nursing (DON) was queried about the lack of signage for contact/droplet isolation precautions and PPE on the unit R#809, R#810 and R#811 resided. The DON reported there had been a miscommunication with the nursing assistant who had removed the PPE and signage and that R#809, R#810 and R#811 remained on contact and droplet isolation precautions. When informed of the discussion with LPN Q, the DON was unsure why LPN Q responded as such and was unable to offer any further explanation. Resident #806, #807, #808 and #813 On 5/14/20 at 8:23 am, a review of the facility's rosters of current residents and of COVID positive residents revealed several residents that were confirmed COVID positive resided on multiple units throughout the facility, despite having a designated COVID unit. Further review of both documents revealed there were four residents that resided on the designated COVID unit that were not COVID positive. At 11:07 am, the Assistant Director of Nursing (ADON) G was queried on why on R#'s 806, 807, 808 and 813 resided on the designated COVID unit if they weren't positive for COVID and stated the four residents were not COVID positive and resided on the designated COVID unit because they were readmissions from the hospital and they wanted to monitor the residents for 14 days. When queried on why the facility had residents who were COVID positive on units (throughout the facility) instead of containing those residents on the designated COVID unit and why the four residents (who were not COVID positive that resided on the designated COVID unit) couldn't be monitored and isolated on a non COVID unit, the ADON G did not provide an answer or any additional information. At 12:53 pm, Nurse Manager (NM) F was observed on the designated COVID unit going into multiple rooms of COVID positive residents picking up lunch trays and assisting staff with care. At 12:58 pm, NM F was observed going into (room number redacted) of a resident (R#806) who was negative for COVID with the same gown that was worn when they exited the resident's room who was COVID positive. At 1:07 pm, observations were made on the designated COVID unit of Certified Nursing Aides (CNA) and Physical Therapist (PT) staff going in and out of resident's rooms who were COVID positive and COVID negative with the same Personal Protective Equipment (PPE) on. Staff failed to sanitize or don on new gowns and PPE when exiting the rooms of COVID positive residents and before entering the rooms of residents who were negative for COVID. A review of CDC's COVID-19 in Nursing Homes guidance documented in part, .Identify space in the facility that could be dedicated to care for residents with confirmed COVID-19 .the unit will be used to cohort residents with COVID-19 .Identify HCP (health care professionals) who will be assigned to work only on the COVID-19 unit . The HCP on the COVID designated unit provided care for the COVID residents and the four residents without COVID that resided on the COVID unit. R#806 was admitted into the facility on [DATE] with a readmission date of [DATE] and [DIAGNOSES REDACTED]. R#806 was not diagnosed with [REDACTED]. The other residents that were negative for COVID and resided on the designated COVID unit were: R#807 who was admitted into the facility on [DATE] with a readmission date of [DATE] and [DIAGNOSES REDACTED]. R#808 who was admitted into the facility on [DATE] with a readmission date of [DATE] and [DIAGNOSES REDACTED]. R#813 who was admitted into the facility on [DATE] with a readmission date of [DATE] and [DIAGNOSES REDACTED]. On 5/18/20 at 7:25 am a Nurses Notes documented in part .writer noted gurgling sounds .observed resident diaphoretic (sweating heavily) .O2 (oxygen saturation) 45 room air .administered 02 went up 55% .Resident transported to (hospital name redacted) . A Clinical Discharge Summary (for R#813) dated May 6, 2020 at 9:53 am documented in part .COVID-19: Negative ., despite R#813's negative COVID results R#813 resided on the designated COVID unit upon readmission into the facility. On 5/14/20 at 4:45 pm, the Administrator was queried on the observation regarding the staff on the designated COVID unit wearing the same gowns to care for both the COVID positive and negative residents and stated the staff were trained on the correct utilization of PPE for COVID and non COVID residents and that additional training will be provided to all staff. A facility policy titled CORONAVIRUS (COVID 19) with a revision date of 4/23/20 was reviewed and revealed no documentation or guidance on placing readmitted residents with a negative COVID status on the designated COVID unit. A facility policy titled Extended use of PPE dated 4/16/20 was reviewed and contained no guidance for staff regarding the use of PPE on the designated COVID unit between residents who are COVID positive and negative. On 5/14/20 at 10:48 AM, review of the facility's screening log for nurses, vendors and visitors form 5/1/20 to 5/14/20 revealed multiple blank entries for the responses to the section that asked about symptoms experienced, temperatures, and name of the person performing the screening. Further review of the documented section which identified the name of the person performing the screen also revealed multiple entries of the staff's own initials that was reporting to work. On 5/14/20 at 10:51 AM, Certified Nursing Assistant (CNA P) was observed to enter the facility and upon checking in at the receptionist desk with Staff Q stated, Finally, someone is up here. On 5/14/20 at 10:56 AM, Staff Q was asked

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) about the facility's screening process for staff, vendors and visitors and reported it was usually the staff with offices in the front lobby. Additionally, Staff Q reported there was usually a button that would ring to the phones or other employees would screen one another. On 5/14/20 at 11:25 AM, an interview was conducted with the ADON. When asked about the facility's screening process for staff, vendors and visitors, the ADON reported the front desk staff usually did that and if on break, or not available, staff would have to page another person. When asked who monitored the screening logs to ensure they were being completed properly, the ADON reported the front desk person and end of month take and put in a log. The ADON further reported daily staff were supposed to ensure everyone was screened and signing per shift. At that time, the ADON was asked to review the screening documentation and confirmed the blank entries and/or staff's own initials documented as name of screener. The ADON was requested to provide a facility's policy for the specific screening process, however none was provided by the end of the survey. On 5/14/20 at 1:45 PM, an interview was conducted with the DON, ADON and Administrator. Upon review of the concerns regarding the facility's screening for staff, vendors and visitors, all acknowledged the concerns. The Administrator was asked about whether there was a facility policy regarding the screenings and reported there was none. Abatement Plan: (Facility name redacted) submits the following Credible Allegation of Compliance outlining the measures it has completed to remove the findings of immediate jeopardy for F880 regarding the facility's alleged failure to follow accepted standards of practice for Infection Control. Residents with the potential to be affected by the alleged deficient practice. Residents placed on Isolation and residents sharing a bathroom with a resident on isolation have the potential to be affected by this practice. Facility assessed all residents on isolation for incontinence and bathroom use to ensure residents sharing a bathroom don't have the potential to spread their infection. Residents that are currently on isolation were reassessed for the potential transfer of Covid-19 infection related shared bathroom use. As of 5/18/2020 the facility has a total of 23 residents that are on Contact/Droplet Precautions. Out of our 4 units the breakdown in isolated patients is as follows: Unit A- Resident #807 -The resident is considered [MEDICATION NAME] isolated due to returning from the hospital on [DATE]. She does not share a bathroom with any other residents. Unit B-Resident #808-The resident is [MEDICATION NAME] isolated to monitor for signs and symptoms of Covid-19 after returning from the Hospital for peg tube placement on 5/6/2020. Resident has no signs and symptoms of Covid-19. The resident is incontinent of both bowel and bladder. Resident #806-The resident is [MEDICATION NAME] isolated to monitor for signs and symptoms of Covid-19 after returning from the hospital on [DATE] for removal of her Jackson Pratt drain. The resident has bilateral Nephrostomy tubes. Both [MEDICATION NAME] isolated residents share a bathroom. Both of these residents have negative Covid-19 test results. These 2 residents are isolated due to return from a Hospital visit according to Company Policy. Resident #814 is in a Private room and the resident is continent of both bowel and bladder and she does not share a bathroom. Unit C has 2 [MEDICATION NAME] isolated residents, Resident #811 and Resident #810. Resident #810 is a previous Covid-19 positive resident that completed 14 days of isolation on the Covid-19 Unit, was transferred to (C-10-b) on 4/30/2020. On 5/7/2020 resident complained of a sore throat during his respiratory screen. The resident also has a [DIAGNOSES REDACTED].#810 history of Covid-19 both residents were placed in [MEDICATION NAME] isolation. Neither resident has displayed any signs or symptoms of Covid-19. Unit D has 16 residents that have been diagnosed with [REDACTED]. All residents, visitors, and staff have the potential to be affected by the inconsistent screening process. Facility implemented a designated staff member to conduct screening of all staff and vendors consistent with CDC guidelines. In addition screening is applicable to anyone entering into the facility and includes Hospice staff, lab techs, x-ray techs, job applicants, new hires, and Physicians. All residents that reside on our Containment unit have a potential to be affected by the deficient practice of PPE use related to ensuring donning new/sanitized PPE when going from one patient to another patient to provide care. Systemic Measures. On 5/14/2020 the facility began in servicing nursing staff regarding the potential for transmission of Covid-19 between residents utilizing the same bathroom. The facility reviewed all residents on contact/droplet precautions that have adjoining bathrooms to evaluate the possibility of transmission. After reviewing and discharging several residents off isolation it was determined there is no longer a risk of transmission related to shared bathrooms between a positive Covid-19 resident and a non Covid-19 resident. Moving forward residents on contact/droplet isolation will not share a bathroom with a non-isolated resident. On 5/14/20 the facility began in-servicing staff on the protocol for screening staff and visitors. Staff will enter and exit through the front door and complete the CDC approved screening requirements prior to the start of work and at the end of their shift have their temperature taken following CDC guidelines and recorded on the facility approved form (see attached). The individuals conducting the screens understand the actions to be taken if staff/visitor does not pass the screening. If facility does not have a designated screener (i.e. off hours) in lobby staff educated that when they allow someone access through the front door they must go to the lobby and conduct screen and that no staff member can screen themselves. Facility started in-servicing staff in all departments on 5/14/20 the process for PPE use/reuse and the appropriate way to don and doff PPE per CDC recommendations (see attached). Facility acknowledged the non-compliance concerns of staff with donning new/sanitized PPE when caring for Non-Covid to Covid-19 positive residents. To ensure compliance staff was educated re-educated on when to sanitize/change PPE when caring for residents on isolation. Administrator and DON will monitor CDC and MDS guidance for updates to policy.