STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235282	A. BUILDING _____ B. WING _____	05/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF KALAMAZOO	1701 S 11TH ST KALAMAZOO, MI 49009

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 -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 884 and MI 1886 . 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 and facility policy to prevent the spread of Covid-19 in 17 of 22 sampled residents (Residents #101, #107, #111, #108, #115, #104, #110, #117, #118, #120, #119, #112, #106, #103, #100, #113, and #114) reviewed for infection control, resulting in an immediate jeopardy when, beginning on beginning on 4/23/2020, facility staff did not implement established infection control standard interventions to provide care for, and prevent the spread of Covid-19 to staff members and residents in the facility. This deficient practice placed all residents at risk for serious harm and/or death. On 4/28/2020 at 1:20 PM, the Nursing Home Administrator was verbally notified and received written notification of the Immediate Jeopardy that was identified on 4/23/20 due to the facility's failure to implement infection control precautions for confirmed COVID -19 positive residents, to inform staff of newly COVID-19 positive residents, and instruct staff to don appropriate PPE when caring for these COVID -19 positive residents. A written plan for removal for the immediate jeopardy was received on 4/30/20 and the following was verified on 5/1/20. 1. On 4/23/20, the 11 residents that tested positive were placed into precautions per CDC guidance on the isolation hall .Facility started moving the residents once rooms on isolation hall were ready at approximately (4:30 PM). Staff members were notified that 11 residents were being moved due to positive test results. Administrator validated that there were appropriate and sufficient amounts of PPE available on the isolation hall to care for the influx of residents. Residents continue to be monitored for symptoms of infection. 2. On 4/23/20 the care plans, orders, and kardex for identified residents were updated to reflect the need for isolation. 3. Beginning on 4/23/20, at (2:00 PM), the Administrator and DON reviewed the need for isolation and proper PPE with the facility staff, which includes aides, temp aides and support aides. No staff has worked without receiving this review 81 of 117 employees have been notified. 4. On 4/23/20 at (6:00 PM), the Administrator, DON, and Unit Manager conducted rounds to ensure that appropriate PPE was available for staff and it was in use. 5. On 4/23/20 at (6:00 PM), the Administrator, DON, and Unit Manager were educated regarding requirements for isolation related to COVID-19 and notification of staff by .Regional Clinical Director. 6. On 4/23/20, residents that reside in the facility were reviewed by the IDT to ensure necessary precaution were in place and staff were wearing appropriate PPE. Following the review residents were in proper isolation with appropriate PPE worn by staff. 7. Beginning on 4/23/20, residents that are considered suspicious for COVID illness will be reviewed with MD/NP and placed into droplet precautions, with their orders, care plans and kardex updated, per CDC guidance. 8. Direct care observations audits will be conducted by the Infection Preventionist/Designee weekly starting on 4/29/20. Audits will be completed on all shifts weekly for 4 weeks and then a minimum of monthly on all shifts. Audits will be reviewed by QAPI and continue until substantial compliance is maintained. 9. Admissions/readmissions will continue to be evaluated per CDC guidelines and the medical record will reflect interventions based on their current assessment. 10. On 4/30/20 at (2:30 PM) education with staff was initiated by the Administrator/designee regarding infection control implementation processes. No staff will work without receiving education. Although the immediate jeopardy was removed on 5/1/20 after the facility began to implement the local health department recommendations, the facility remained out of compliance at a scope of widespread with a severity of no actual harm but the potential for more than minimal harm that is not immediate jeopardy due to all facility staff had not yet received education and the state agency had not yet verified sustained compliance. Findings include: Review of the facility's Coronavirus Surveillance policy, dated 3/11/20, revealed .Coronavirus is [MEDICAL CONDITION] that causes mild to severe respiratory illness .COVID-19 (short for coronavirus disease 2019) is a new respiratory disease caused by a novel (new) coronavirus .What is currently known is that it is spread person-to-person, mainly between people who are within 6 feet of one another through respiratory droplets produced when an infected person coughs or sneezes .This facility will implement heightened surveillance activities for coronavirus illness during periods of transmission in the community and/or during a declared public health emergency for the illness What is currently known is that it is spread person-to-person, mainly between people who are within 6 feet of one another through respiratory droplets produced when an infected person coughs or sneezes .The Infection Preventionist will monitor the status of COVID-19 outbreak through the CDC website, and will monitor for changes in prevention, treatment, isolation, or other recommendations .Heightened surveillance activities will be implemented to limit the transmission of COVID-19 . Staff shall follow established procedures when COVID-19 is suspected .Considerations for managing residents with suspected or confirmed COVID-19 infection .Use clinical features and epidemiologic risk for making a determination that COVID-19 infection is suspected. Test for COVID-19 in accordance with current CDC guidelines . Review of the facility's Isolation Gown Use during Infection Outbreaks policy, dated 4/10/20, revealed .The use of isolation gowns during infection outbreaks will be in accordance with current CDC guidelines . Review of the State of Michigan Operations Manual, revealed .RECOGNIZING, CONTAINING AND REPORTING COMMUNICABLE DISEASE OUTBREAKS .Refer to CDC guidelines for current recommendations on standard and transmission-based precautions .INFECTION CONTROL POLICIES AND PROCEDURES .The facility must develop and implement written policies and procedures for the provision of infection prevention and control. The facility administration and medical director should ensure that current standards of practice based on recognized guidelines are incorporated in the resident care policies and procedures . Review of the Centers for Disease Control and Prevention website, updated 4/13/20, revealed .If COVID-19 is suspected, based on evaluation of the resident or prevalence of COVID-19 in the community, follow the Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. This guidance includes detailed information regarding recommended PPE . HCP (Health care providers) who enter the room of a patient with known or suspected COVID -19 should adhere to Standard Precautions and use a respirator (or facemask if a respiratory is not available), gown, gloves, and eye protection (droplet precautions) . If there are shortages of gowns, they should be prioritized for: aerosol generating procedures .care activities where splashes and sprays are anticipated .high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP. Examples include: . dressing . bathing/showering .transferring .providing hygiene .changing linens .changing briefs or assisting with toileting .device care or use . https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html In an interview on 4/22/20 at 1300, Nursing Home Administrator (NHA) A and Infection Control Preventionist (ICP) C indicated the facility had 17 COVID-19 residents. NHA A indicated the facility created a COVID -19 positive hall on Unit D that adhered to droplet precautions. The 17 COVID-19 positive residents had been moved from Unit D to Unit B. NHA A indicated the remaining residents on Unit D with negative COVID-19 test results were deemed presumptive COVID-19 positive due to the potential of communal spread of COVID -19. NHA A indicated Unit D residents were placed in droplet precautions, and staff were required to don gown, gloves, and a face mask at all times when working on the hall. ICP C indicated on Unit A Resident #102 had tested positive for COVID-19 and Resident #103 was exposed to a COVID-19 resident from Unit D; and both of these residents remain on Unit A and

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) were placed on droplet precautions. ICP C indicated have tested a total of 41 residents from Unit A and C, suspecting those residents were also exposed to COVID-19 through communal living. Units A and C were not placed on droplet precautions. During an observation on 4/22/20 at 9:35 AM, there were no signs on Unit D's interior door visable from the nursing unit, (presumptive COVID-19 positive hall) that indicated to staff and visitors that Unit D's residents were under any kind of transmission-based precautions and no one should enter without instructions on PPE use. In an interview on 4/22/20 at 2:00 PM, NHA A indicated Unit D did not have signage that indicated the hall was on isolation or transmission based precautions NHA A indicated there should be a sign on Unit D's indicated this and no one should enter through that door without speaking to a staff member. In an interview on 4/23/20 at 9:10 AM, NHA A indicated 13 of 41 residents that were tested from Unit A and C had tested COVID-19 positive. NHA A indicated Unit A had 5 COVID- 19 positive residents (#100, #101, #102, #103, and #112) and Unit C had 8 COVID-19 positive residents (#104, #105, #106, #107, #108, #109, #110, #111). NHA A indicated Residents #101 and #103 were already in droplet precautions due to exposure. NHA A indicated would move the 11 other COVID-19 positive residents to Unit B and place them in droplet precautions. In an interview on 4/23/20 at 10:30 AM, NHA A indicated the facility has had 4 staff members who had tested positive for COVID-19. NHA A reported they would not test anymore of their staff members for COVID-19. In an interview on 4/23/20 at 10:40 AM, met with NHA A, ICP C, Director of Nursing B (DON), and Regional Nurse Consultant 2 BB (RNC 2). NHA A indicated she was not going to test staff members for COVID-19 but would instead require all staff to wear a N95 mask (respiratory mask) and wear a gown throughout the facility to protect residents not infected with COVID-19 from staff potentially infected but asymptomatic. In an interview on 4/23/20 at 11:40 AM, Health Department Director CC (HDD) indicated would come to the facility and hold an event to test all staff members at the facility. HDD CC indicated would use the health department's test kits and the testing would be free. HDD CC indicated it strongly recommended the staff testing to determine a timeline to know when to potentially lift isolation precautions, to track staff to resident exposure to [MEDICAL CONDITION], to track spread through the building, and to determine where infection control education could be directed. In an interview on 4/23/20 at 11:50 AM, NHA A indicated received the offer from the Health Department regarding a staff testing event for COVID-19. NHA A later indicated at 1:00 PM that the facility choose not to allow the COVID-19 testing event to occur. During an observation on 4/23/20 at 12:15 PM, no staff on Unit A, Unit C, or in common areas were observed wearing gowns to protect residents from potentially being exposed to COVID -19 positive staff. During an observation on 4/23/20 at 10:00 AM, on Unit A the newly diagnosed COVID-19 Residents #100, #101 and #112 did not have signs (i.e. Please see nurse before entering room) on their doors alerting staff that those residents were COVID-19 positive. No bins of PPE were observed outside their rooms or anywhere on the hall. Resident #101 Review of a facility Admissions Record revealed Resident #101 was an [AGE] year-old female originally admitted to the facility on [DATE] that was diagnosed positive for COVID-19 on 4/23/20. During an observation on 4/23/20 at 10:15 AM, Certified Nursing Assistant O (CNA) on Unit A entered COVID-19 positive Resident #101's room to give care. CNA O did not don a gown or eye wear to provide care. In an observation and interview on 4/23/20 at 10:05 AM, Nurse Educator E (NE) was working on Unit C and indicated 8 of 20 residents on Unit C had tested positive for COVID-19 earlier that morning. No signs (i.e. Please see nurse before entering room) were observed on Resident #104, #105, #106, #107, #108, #109, #110, or #111's doors alerting staff which residents were COVID-19 positive. No bins of PPE were observed outside of the COVID-19 positive rooms nor were they observed in any other space on Unit C. Review of a facility Admissions Record revealed Resident #116 was a [AGE] year-old female originally admitted to the facility on [DATE] that was diagnosed positive for COVID-19 on 5/1//20. During an observation on 4/23/2020 at 12:20 PM, blue surgical gown and yellow gown where hanging on the left inside wall as you step into Resident #101's room on a white hook next to the plastic box holding the glove box. The gowns were touching the back of the TV, the side and back of a three-drawer dresser, colored pictures on the wall, power cords for the electronic items, and the resident's waste receptacle. Resident #101 was sitting in a wheelchair facing the TV and the door entry and she proceeded to perform coughing with no mask placed to cover her mouth. Resident #101 was approximately 5 feet away from the entry door which was left open at this time and during multiple observations on this date. Certified Nursing Assistant T donned the blue surgical gown by grabbing it from inside the door of the resident's room without gloves on. No face shield was donned prior to entering the room to assist roommate, Resident #116 with care. CNA T assisted Resident #116 to use the restroom, back to bed and to get situated prior to exit. Upon exit from the room, CNA T hung the blue surgical gown back on the white hook behind the Resident #101's TV. No sanitization of the gown occurred and it was hung back up on the white hook on the wall. CNA T utilized hand sanitizer after exiting the room, which was hung on the wall in the hallway. Resident #107 Review of a facility Admissions Record revealed Resident #107 was a [AGE] year-old male originally admitted to the facility on [DATE] that was diagnosed positive for COVID-19 on 4/23/20. In an observation on 4/23/20 at 10:10 AM, on Unit C Resident #107 was pacing up and down the hall. Temporary Nursing Assistant R (TNA) followed Resident #107 up and down the hall redirecting him from entering other resident rooms and pounding on both exit doors on opposite ends of the hall. TNA R was not wearing a gown or gloves when frequently touching and redirecting Resident #107. No sanitization of areas that Resident #107 repeatedly touched was observed. In an observation on 4/23/2020 at 11:00 AM, Registered Nurse (RN) E was observed assisting Resident #107, in the hallway by the nursing station room, with wearing a facial mask. RN E was observed not wearing a gown, gloves, or goggles/face shield. Registered Nurse (RN) E did not utilize use of appropriate personal protective equipment (PPE) when encountering a COVID-19 positive resident. In an observation on 4/23/2020 at 11:00 AM, Temporary Nurses Aid (TNA) R was assisting Resident #107 with applying hand sanitizer. TNA R was observed not wearing a gown or gloves. TNA R did not utilize use of appropriate personal protective equipment (PPE) when encountering a COVID-19 positive resident. Resident #111 Review of a facility Admissions Record revealed Resident #111 was an [AGE] year-old female originally admitted to the facility on [DATE] that was diagnosed positive for COVID-19 on 4/23/20. During an observation and interview on 4/23/20 at 1:30 PM, on Unit C no signs were observed on any COVID-19 positive resident's doors. No bins of PPE were observed outside of the COVID-19 positive rooms. CNA X and O entered COVID-19 positive Resident #111's room. CNA X and O provided a bed bath and incontinence care for Resident #111. Neither CNA wore a gown or eye protection. CNA O indicated was not instructed by management to wear a gown or eyewear when providing care for Resident #111 and asked, should we be?. CNA X indicated was not instructed by management to wear a gown with all residents to protect the residents from staff transmitted COVID-19. During an observation on 4/23/20 at 2:00 PM, on Unit C staff members were placing signs on doors to indicate which residents were COVID-19 positive. No PPE bins were observed on the Hall. Resident #108 Review of a facility Admissions Record revealed Resident #108 was a [AGE] year-old male originally admitted to the facility on [DATE] that was diagnosed positive for COVID-19 on 4/23/20. During an observation on 4/23/20 at 2:15 PM, Housekeeper EE (HK) entered COVID-19 positive Resident #108's room for a daily cleaning. No gown or eye protection were observed. HK EE cleaned within 1 foot of Resident #108 seated in a wheelchair. HK EE placed hands on Resident #108's wheelchair armrest and squatted down to pick debris off the floor. Resident #115 Review of a facility Admissions Record revealed Resident #115 was a [AGE] year-old male originally admitted to the facility on [DATE] that was considered presumptive positive for COVID-19 on 4/21/20 and test results were pending. Resident #115's roommate was Resident #107 who had tested COVID-19 positive on 4/23/20. Resident #115 was retested and was COVID-19 positive on 4/29/20. During an observation on 4/23/20 at 2:20 PM, TNA R on Unit C paced up and down the hall arm and arm with Resident #115. No gown was observed or eye protection. Resident #104 Review of a facility Admissions Record revealed Resident #104 was a [AGE] year-old female originally admitted to the facility on [DATE] that was diagnosed positive for COVID-19 on 4/23/20. During an observation on 4/23/20 at 2:25 PM, COVID-19 positive Resident #104 was on her hands and knees in the threshold of her room. NE E assessed Resident #104 and determined it was safe to transfer her. NE E and CNA X assisted Resident #104 off the floor and into her wheelchair. No gowns or eye protection were observed. In an interview on 4/23/20 at 3:00 PM, Nurse Educator (NE) E indicated Resident #104 was not hurt and sometimes put herself on the floor; it was not a emergency. NE E indicated was aware Resident #104 was COVID-19 positive and indicated should have used a gown and eye protection when assisting Resident #104. During an observation on 4/23/20 at 2:35 PM, CNA G entered COVID-19 positive Resident #104's room to provide care and did not use a gown or eye protection. Resident #110 Review of a facility Admissions Record revealed Resident #110 was an [AGE] year-old female originally admitted to the facility on [DATE] that was diagnosed positive for COVID-19 on 4/23/20. During an observation on 4/23/20 at 2:50 PM, on Unit C, COVID-19 positive Resident #110 was seated in the dining area without a face mask on, within approximately 2 feet from 2 other residents that tested COVID- 19 negative. The residents touched the same communal objects in the dining room (puzzles, plastic toys, and the table). No distancing was observed or sanitization of the communal objects or the resident's hands were observed. During an observation on 4/23/20 at 2:55 PM, on Unit C empty bins to store PPE were placed on hall. No PPE was stocked inside the bins. During an observation on 4/23/20 at 2:57 PM,

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) COVID-19 positive Resident #107 paced up and down Unit C, grabbing handrails, banging on exit doors, and touching the keypad to input the exit code. No sanitization of surfaces observed. Presumptive COVID -19 Resident #115 followed behind Resident #107 touching the handrails, exit doors, and keypad. Both residents were observed to continually circle the hall for approximately 10 minutes. During an observation on 4/23/20 at 5:30 PM, Office Manager EE (OM) entered Unit C wearing a gown, indicated was moving Resident #110 to the COVID positive Unit B. Resident #110 was seated in the hallway in her wheelchair with NE EE standing directly behind her touching her wheelchair, no gown or gloves were observed. OM EE placed a mask on Resident #110's face. OM E had no gloves and no hand hygiene was observed. OM EE began pushing Resident #110's wheelchair down the hall with no gloves. NE E stopped OM EE and advised OM EE to put on gloves and find Resident #110's foot pedals. OM EE donned gloves, no hand hygiene was observed prior to donning. CNA G stood to the right of Resident #110's wheelchair, indicated her foot pedals were located on the back of the wheelchair. CNA G with no gown or gloves removed the foot pedals from the bag, placed the foot pedals on Resident #110's wheelchair, squatting directly in front of her touching her legs and shoes to place pedals. OM EE exited Unit C and took Resident #110 to Unit B. On 4/30/20 returned to the facility to review the the immediate jeopardy removal plan. In an interview on 4/30/20 at 10:30 AM, ICP C indicated 12 of 15 residents on Unit A were now displaying signs and/or symptoms of COVID-19. The facility decided to test and presume those 12 residents were COVID-19 positive and place them in droplet precautions on 4/29/20. ICP C indicated the remaining 3 residents were not placed-on droplet precautions. ICP C indicated presumptive COVID-19 positive Resident #115 from Unit C was confirmed to be COVID-19 positive on 4/29/20 and moved to the droplet isolation Unit B. This was Unit C's 9th COVID-19 positive resident. ICP C indicated the remaining residents on Unit C had not been placed on droplet precautions. ICP C indicated all residents on Unit D were COVID-19 positive except for 4 female residents. Those 4 female residents were placed were placed in rooms together and their rooms had negative signs on their doors. ICP C indicated on Unit D the staff wore the same gowns in out of all the COVID positive rooms to preserve PPE. ICP C indicated to protect the COVID-19 negative residents from further COVID-19 exposure, prior to entering the negative rooms the staff should remove their dirty gowns, hang them on a hook outside the room, and perform hand hygiene. ICP C indicated the staff should enter the negative room, don the clean gown found hanging on the back of the door, don gloves, and provide care. ICP C indicated to exit the staff should doff the clean gown and gloves, hang the gown back up inside the room, perform hand hygiene, and don the dirty gown hanging outside the room. In an interview on 4/30/20 at 10:30 AM, ICP C was on Unit A and indicated after contacting the Health Department today went ahead on their recommendation to place the remaining 3 of 15 residents from Unit A (not showing signs or symptoms) on droplet precautions. ICP C indicated was on the hall ensuring all 15 residents had signs on their doors and PPE bins outside their rooms. In an interview on 4/30/20 at 2:00 PM, NHA A indicated on Unit C there were several sets of roommates where one roommate tested positive for COVID-19 and one roommate tested negative for COVID-19. NHA A indicated did not place both roommates in droplet precautions and presume that the negative roommate was COVID-19 positive due to exposure. NHA A indicated moved the COVID-19 positive residents to the droplet isolation Units B and D. NHA A indicated contacted the Health Department and they advised if there was no COVID-19 positive resident on Unit C, then did not have to put the COVID-19 negative roommates in droplet precaution. In an interview on 5/1/20 at 10:15 AM, Health Department Registered Nurse SS (HD RN) indicated the facility did not call the morning of 4/29/20 (9th positive on Unit C) and inquire whether the facility should place the roommates of COVID-19 positive residents in droplet precautions. HD RN SS indicated would have recommended placing the roommates on droplet precautions, as well as, the rest of Unit C due to communal exposure. HD RN SS indicated the facility called on 4/30/20 at approximately 5:00 PM after 12 residents on Unit A displayed signs and symptoms of COVID-19 were tested . HD RN SS indicated recommended not testing anymore residents and consider the entire building presumptive COVID-19 positive and place everyone in droplet precautions. In an interview on 5/1/20 at 11:50 AM, Health Department Medical Director TT (HD MD) indicated the facility has not been forthcoming with reporting of COVID-19 positive test results and deaths. HD MD TT indicated the facility has the responsibility to report communicable disease deaths within 2 hours of the death to the Health Department. HD MD TT indicated the facility was behind on reporting COVID-19 related deaths by 6 to 7 days. HD MD TT indicated the facility had struggled to communicate the timeline of the COVID-19 illness and its progression throughout the facility. During an observation on 4/30/20 at 11:15 AM, CNA MM was on Unit A (presumptive positive droplet precautions) and in a resident's room wearing a gown and gloves. CNA MM' exited the room, answered the call light in the adjacent room, exited, and entered a room across the hall to answer another call light. CNA MM wore the same gown and gloves to each room and no hand hygiene was observed before or after entering each room. Resident #117 Review of a facility Admissions Record revealed Resident #117 was a [AGE] year-old female originally admitted to the facility on [DATE] that was considered presumptive positive for COVID-19 on 4/29/20 and test results were pending. Results for the COVID-19 testing were confirmed positive between 5/1/20 and 5/5/20. During an observation on 4/30/20 at 11:25 AM, CNA T entered Resident #117's room with a mask, a gown on and no gloves. CNA T squatted down next to Resident #117's wheelchair, placing both hands on the wheelchair arm. CNA T picked up Resident #117's call light from the floor and pinned it to the resident's gown and patted her hand. No hand hygiene observed on exit. Resident #118 Review of a facility Admissions Record revealed Resident #118 was a [AGE] year-old female originally admitted to the facility on [DATE] that has tested negative for COVID -19. During an observation on 4/30/20 at 12:20 PM, lunch was served on Unit D, that was in droplet precautions, with 4 COVID-19 negative residents that required clean gowns for entry into their rooms. CNA NN, G, and TNA OO were delivering lunch to the residents. Lunch was served from a double shelved pushcart. The meals were prepared from the kitchen in a clamshell Styrofoam container and those containers were piled up in no order on the bottom shelf. Several cardboard boxes were placed on the top shelf of the cart and the boxes contained packaged drinks, plastic cutlery, and packaged snacks. The staff would hand carry each lunch container and cutlery to the rooms and then ask the residents which kind of drink and snack they wanted. All three staff members wore the dirty gowns, picked up the lunch containers and cutlery and dropped food to the COVID-19 positive rooms first. The staff with dirty' gowns on, then leaned against the boxes of drinks and snacks, and reached into the boxes to remove desired items. Minimal hand hygiene was observed between delivery of food into COVID-19 positive rooms and the pushcart. The four lunch containers for the COVID negative rooms were almost at the very bottom of the container pile. The staff serving lunch had to handle the lunch containers for the negative COVID-19 residents multiple times to search for the COVID positive resident's food. During an observation on 4/30/20 at 12:30 PM, COVID -19 negative Resident #118 was seated in bed, on the outside of her door was a large sign that said Negative. CNA NN entered Resident #118's room with the dirty gown on and gloved hands. No gown change into the clean gown, removal of used gloves, or hand hygiene was observed. CNA NN opened Resident #118's lunch container and place it on her overbed table and raised the table to eating height. CNA NN opened Resident #118's plastic cutlery and mustard and placed the cutlery and mustard inside the open lunch container touching the inside of the container with gloved hands. CNA NN doffed gloves and exited Resident #118's room. CNA NN retrieved a water cup off the pushcart and brought it back to Resident #118, no gown change or hand hygiene observed. Resident #120 Review of a facility Admissions Record revealed Resident #120 was a [AGE] year-old female originally admitted to the facility on [DATE] that has tested negative for COVID -19. During an observation on 4/30/20 at 12:45 PM, CNA NN exited Resident #118's room, answered a call light in a COVID positive room and touched the overbed table and wheelchair. No hand hygiene was performed when entering or exiting the room. CNA NN walked to the pushcart of food, picked up a lunch container and plastic cutlery; and placed these items just inside COVID -19 negative Resident #120's room (on the outside of the door was a large sign that said Negative). No hand hygiene was observed. CNA NN returned to the pushcart to the boxes and removed a fruit cup and a drink. CNA NN entered Resident #120 's room with same dirty gown and delivered the drink and fruit cup; and assisted Resident #120 with setup. No hand hygiene was observed or removal of dirty gown prior to entry to a clean or negative room. In an interview on 4/30/20 at 12:50 PM, CNA NN indicated did not change out of the dirty gown into a clean gown to enter Resident #118 or #120's room. CNA NN indicated forgot they were COVID-19 negative and needed a different gown. Resident #119 Review of a facility Admissions Record revealed Resident #119 was an [AGE] year-old female originally admitted to the facility on [DATE] that has tested negative for COVID -19. During an observation on 4/30/20 at 12:35 PM, Resident #119 was lying in bed in her room, on the outside of her door was a large sign that said Negative. CNA F entered Resident #119's room wearing with a dirty gown. No hand hygiene was performed, and no gloves were donned. CNA F leaned against Resident #119's bed, assisted Resident #119 to a seated position, adjusted her pillows, blankets, and handled her bed remote. CNA F exited Resident #119's room and walked to the pushcart, found her lunch container and brought it back to her room. No hand hygiene was observed or dirty gown removal. CNA F setup and fed Resident #119 in the dirty gown with no gloves.

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MEDILODGE OF KALAMAZOO	**1701 S 11TH ST KALAMAZOO, MI 49009**

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 -** Many	(continued... from page 3) Review of Coronavirus Surveillance policy reviewed/revised on 3/11/2020 revealed, .6. Residents will be monitored for signs and symptoms of coronavirus illness: fever, cough, shortness of breath. The physician will be notified immediately, if evident. Staff shall follow established procedures when COVID-19 is suspected. 7. Considerations for managing residents with suspected or confirmed COVID-19 infection: a. Use clinical features and epidemiologic risk for making a determination that COVID-19 infection is suspected. Test for COVID-19 in accordance with current CDC (Centers for Disease Control and Prevention) guidelines; b. Collaborate with the local health department regarding a coordinated transfer, unless it is determined that transfer is not required. For example, the resident does not require a higher level of care and the facility can adhere to recommended infection prevention and control practices (with modifications if no airborne infection