STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235103	A. BUILDING _____ B. WING _____	07/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SKLD BELTLINE	2320 E BELTLINE SE GRAND RAPIDS, MI 49546

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** - Many	**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 properly maintain infection control practices when using personal protective equipment (PPE) in 5 of 5 sampled residents (Resident #100, #101, #102, #103 and #104), review during a COVID-19 Infection Control Survey, resulting in the potential for cross-contamination, and the development and spread of disease, which places a vulnerable population at high risk for infections. Findings include: Review of the All Staff Huddle Education dated 7/3/2020, revealed #1-PHYSICAL ENVIRONMENT BARRIERS: * All DOORS to resident rooms should remain closed as much as possible on 700, 100 & 500 Hall, *Any residents with Isolation carts should also have their Door closed as much as possible * The Double Doors to 700, 100 & 500 must remain closed at all times * Resident & Staff, stay on your units, minimize travel in facility as much as possible *If a resident is out of their room or sitting in the doorway of room they must wear a mask. Please document any refusals. *Social Distancing! Remain 6' apart from others when possible, resident too. #2-HAND WASHING: *Wash/sanitize hands in/out of every resident room, after touching contaminated or high touch surfaces, whenever soiled * Assist residents to wash hands before/after toileting, meals, and when visibly soiled .#3-PERSONAL PROTECTIVE EQUIPMENT (PPE): *All staff will wear a surgical facemask. Do not pull down your mask to talk to others, keep it secured covering your nose & mouth if you touch your mask sanitize your hands. Discard mask after 1 shift. * 700 & 500 Hall Staff will wear N95 mask, gown, face shield while on the unit. *N95 mask - keep up to 5 shifts, discard if soiled before then. Save mask in paper bag, label with name and date. *Face Shield/goggles - wipe with bleach wipe after use, save up to 5 shifts unless soiled before then, store in plastic O2 bag label with name and date. * Gowns - discard at the end of shift or change if soiled before then. * .(SIC) During an observation on 7/21/2020 at 2:35 PM, Certified Nursing Assistant (CNA) P in the 100 hall was wearing a surgical mask loosely on their face, the mask was underneath the nose leaving the nose exposed, CNA P dropped a pen on the floor, bent to pick the pen off the floor, placed the pen in pocket of scrub shirt, did not clean pen or clean hand, CNA P went in the infection control office located on the hall and sat in a chair. During an observation on 7/21/2020 at 2:45 PM, CNA V was in the 200-hall with a surgical mask pulled down below his chin talking to Registered Nurse (RN) Y who had mask on properly and was getting ready to leave to dispense medication to resident, CNA V left the area and went back to the charting room. During an interview and observation on 7/22/2020 at 2:30 PM, CNA V was in the 200-hall pulling his mask away from his face stated, sorry just catching breath so hot, hard to breath, probably because I am overweight. CNA V did not wash hands after touching the mask. CNA V went directly into residents' room did not see sanitizer hands before entry door was closed for care. During an interview on 7/22/2020 at 3:09 PM Infection Control (IC) Registered Nurse (RN) (ICRN) D reported that staff on the 500-hall and 700-hall would need to wear gown, shield or goggles, N-95, and gloves per the sign on the door. During an observation and interview on 7/22/2020 at 11:17 AM, Laundry Aide (LA) Swas coming up the 700-hall in gloves and a surgical mask collecting laundry, came out the double doors, took off his gloves, went to central bath appeared to not see a trash can, went across the hall to the soiled utility room key pad opened the door, placed gloves in the trash can and left the room. LA S push his laundry cart down the hall and stopped at a hand sanitizer and cleaned his hand. LA S reported that there was a sink in the soiled utility room, but he liked to use the hand sanitizer. LA S reported that at this time he did not have to go into any resident rooms to pick up laundry on the 700 hall the laundry was setting in the hall. During an interview on 7/22/2020 at 11:26 AM, Laundry/Housekeeping Supervisor (LHS) T reported that employees that work on the 700-hall need to have on mask, yellow gown, and gloves when they pick up laundry. LHS T reported that they only need to have on a surgical mask because they are not going in the resident rooms. During an observation on 7/21/2020 at approximately 3:10 PM, Maintenance Assistant staff were standing inside the doorway of the 500-hall in PPE holding the double door open to the Covid unit speaking with a staff member on the other side of the door. The door was open approximately 2 feet wide. During an observation on 7/22/2020 at 12:38 PM, CNA Q was at double door to 500- hall with her head out as if looking for someone on and off for 4 minutes, staff member came had a discussion, door was open approximately 1 to 2 foot. During an interview on 7/23/20 at 10:33 AM, Nursing Home Administrator (NHA) A and Infection Control (IC) Registered Nurse (RN) (ICRN) D reported the door on the 500-hall was not to be opened to talk through, on the Covid unit we encourage the use of the walkie talkie on the wall outside the unit to minimize the in person communication on the unit, the nurse on the unit has a walkie talkie and the staff should be communicating with the walkie talkie. Resident #100 Review of an Admission Record revealed Resident #100 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 7/6/20 revealed a Brief Interview for Mental Status (BIMS) score of completed by facility staff, which indicated Resident #100 was cognitively impaired. Review of the Admission Documentation dated 6/26/20, revealed She (Resident #100) and her (person caring for her) have been bouncing around to different family members' homes and guardian has adult protective service (APS) involved hoping to place in nursing home. In order to consider (name of resident) for admission, we will need a COVIC test and the attached information . . (SIC) Review of the Long-Term Care Respiratory Surveillance Line Listing dated 7/1/20, revealed Resident #100 tested Positive for COVID on 7/1/20. Review of the nursing notes dated 7/2/2020 at 3:19 PM, revealed Resident's legal guardian notified of room change to COVID unit and positive COVID-19 test results. During an observation on 7/21/2020 at approximately 3:12 PM CNA Q was standing in the doorway by the exit with a surgical mask on loosely, the mask was visibly under her nose and her hands were on her mask, then pushing her hair back from her face towards her pony tail, she was leaning on the hand railing, then every so often would go over and help (Resident #100) who was sitting in a chair by the door with straws on a table. Then CNA Q would step back adjust her face mask, smooth her hair, lean on the railing or see if the other resident (Resident #101) sitting approximately 6 feet away needed anything and she would touch that resident's wheelchair to help her. Activity Director (AD) R came and took Resident #100 for a walk outside. CNA Q cleaned (Resident #101's) hands and her own then leaned back against the railing, the resident touched her gown after touching her face mask with her left hand (resident had an N95 mask on) was touching railing, CNA Q continued to touch face mask and push hair back, Resident #100 was returned to the building and CNA Q attempted to help her settle back in seat. CNA Q or AD R did not offer to clean Resident #100's hand after her walk. Resident #101 Review of an Admission Record revealed Resident #101 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 5/15/2020 revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #101 was cognitively impaired. Review of the nursing notes dated 7/2/20 at 5:20 PM, revealed Resident's (#101) guardian notified of positive covid-19 test results from swab yesterday. (SIC) During an interview on 7/23/2020 at 1:57 PM, Certified Nursing Assistant (CNA) O reported that she worked mostly on station one (100 and 200 hall), and sometimes 400 hall. CNA O reported that they were required to wear the thin blue mask (surgical mask) for those halls. CNA O reported that there was a resident (Resident #101) that tested positive on the 100 hall and in passing to let her outside she would see her without her mask and go to her room to get it for her and help her put it on. Resident #102 Review of an Admission Record revealed

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 -** Many	(continued... from page 1) Resident #102 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED].[MEDICAL CONDITION] bladder, and [MEDICAL CONDITION]. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 7/1/19 revealed a Brief Interview for Mental Status (BIMS) score of 11, out of a total possible score of 15, which indicated Resident #102 was cognitively impaired. Review of the nursing note dated 7/6/20 at 10:07 PM, revealed Received call from nurse at ED for update. Patient was admitted to the inpatient unit for pneumonia, [MEDICAL CONDITION] exacerbation and positive covid test. (SIC) Resident #103 Review of an Admission Record revealed Resident #103 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 7/6/20 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #103 was cognitively intact. Review of the Hospital Transfer records dated 6/25/2020 (no time), revealed persistent positive covid. Resident #104 Review of a Face Sheet revealed Resident #104 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 7/12/2020 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #104 was cognitively intact. Review of the Hospital Transfer Referral dated 7/2/2020, revealed Positive Covid-19 with associated acute respiratory illness . During an observation on 7/22/2020 at 12:15 PM, Resident #100 was in room, CNA Q delivered tray with surgical mask on loosely, nose exposed, Resident #100 was sitting in room and CNA Q bent over and assisted to prepare tray for her. During an observation on 7/22/2020 at approximately 12:18 PM, CNA Q delivered lunch trays to Resident #103, 104 and then #102 assisting them as needed with prep for lunch. CNA Q did not have her surgical mask securely on her face, her nose was still exposed. During an interview on 7/22/2020 at 12:50 PM, CNA Q stated she just wears this one (the surgical mask), should I wear an N-95? CNA Q reported she had seen other people wear surgical mask on this hall so that was why she did, but the PPE sign on the door for this hall did say to wear an N95 mask. During an interview on 7/22/20 at 7:00 PM, RN K reported that the nurse was responsible for infection control which included PPE. RN K reported that he did not realize that the mask CNA Q had on was not an N95 mask, he did not see it fall below her nose.