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 _____	05/27/2020

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that a portable oxygen tank was properly secured while left unattended for one resident (R#704) reviewed for oxygen, resulting in the potential for the tank to be knocked over, causing a potential rocketing of the cylinder and injury to residents. Findings include: On 5/26/20 at 11:18 AM, upon entering the facility's designated COVID-19 unit, an observation of the common area across from the nursing desk revealed a full oxygen tank was positioned on top of a chair, unsecured and leaning slightly onto the chairback. On 5/26/20 at approximately 11:20 AM, the Assistant Director of Nursing (ADON) entered the unit and when queried about the placement of the oxygen tank, the ADON stated That shouldn't be there. When queried about who the oxygen tank was for, and how long it had been placed there, the ADON began to question Staff A and Registered Nurse (RN B). Staff A proceeded to pick up the oxygen tank without the use of a storage holder and carried the full tank into a room located behind the nursing desk. RN B reported, That's (R#704's name) she just left for [MEDICAL TREATMENT] and I put a full one on. When the ADON questioned RN B regarding further details of why the oxygen tank had been left unsecured, RN B reported, Well it's not there now. At approximately 11:25 AM, the ADON was asked to observe the room the oxygen tank had been moved to. Further observation revealed the oxygen tank had been placed into the unit's Clean Utility Room into a metal storage cart next to the emergency response cart. A review of the clinical record revealed R#704 was admitted into the facility on [DATE], and readmitted on [DATE]. According to the face sheet record, R#704's [DIAGNOSES REDACTED]. A review of R#704's current physician orders [REDACTED].<90%. On 5/5/20, droplet isolation precautions r/t (related to) COVID 19. On 5/6/20, [MEDICAL TREATMENT] at ([MEDICAL TREATMENT] Clinic Name) on Mondays, Wednesdays and Fridays. On 5/26/20 at 1:00 PM, an interview was conducted with the Administrator and ADON. When informed of the observation of the oxygen tank and concerns regarding lack of proper storage, the Administrator acknowledged the concern and reported staff were to be re-educated. When asked about R#704 and the report that RN B had changed the oxygen tank to a full one and why was there a full tank on the chair, the Administrator reported he would follow up. On 5/26/20 at 1:45 PM, the Administrator reported, We've called the [MEDICAL TREATMENT] (facility) and confirmed (R#704) has a full tank of oxygen. The Administrator was requested to provide a facility policy regarding storage and transport of oxygen. Review of the facility's Oxygen Storage & Assembly policy dated, October 2011 documented, in part: .Store all oxygen in an upright position in racks if racks are not available, oxygen tanks are secured with chains that fit snuggly around the cylinders and are secured to an exterior stationary wall .Small Tank .Place cylinder in stand or cart .
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review, the facility failed to maintain adequate infection control practices on the dedicated COVID-19 unit of the facility resulting in the lack of proper sanitization of a potentially contaminated oxygen tank and the potential spread of infectious organisms to residents residing within the dedicated COVID-19 unit. Findings include: On 5/26/20 at 11:18 AM, upon entering the facility's designated COVID-19 unit, an observation of the common area across from the nursing desk revealed a full oxygen tank was positioned on top of a chair, unsecured and leaning slightly onto the chairback. On 5/26/20 at approximately 11:20 AM, the Assistant Director of Nursing (ADON) entered the unit and when queried about the placement of the oxygen tank, the ADON stated That shouldn't be there. When queried about who the oxygen tank was for, and how long it had been placed there, the ADON began to question Staff A and Registered Nurse (RN B). Staff A proceeded to pick up the oxygen tank without the use of a storage holder and carried the full tank into a room located behind the nursing desk. At approximately 11:25 AM, the ADON was asked to observe the room the oxygen tank had been moved to. Further observation revealed the oxygen tank had been placed into the unit's Clean Utility Room into a metal storage rack next to the emergency response cart. The ADON was queried about the lack of sanitization of the oxygen tank prior to placing into the clean utility room and reported, Should've been sanitized before putting in there. On 5/26/20 at 1:00 PM, an interview was conducted with the Administrator and ADON. When informed of the observation of the oxygen tank and concerns regarding lack of sanitization, the Administrator acknowledged the concern and reported staff were to be re-educated. On 5/26/20 at 1:45 PM, the Administrator reported, We've disinfected the whole room cause it's all been contaminated.

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.