STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235715	A. BUILDING _____ B. WING _____	05/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WELLBRIDGE OF FENTON	**901 PINE CREEK DRIVE FENTON, MI 48430**

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 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** This citation pertains to Intake Numbers MI 811 and MI 897. Based on observation, interview and record review, the facility failed to enact Infection Prevention and Control program policies to ensure Infection Surveillance was completed for all residents with signs and symptoms of infection to accurately capture the onset date of symptoms to ensure preventive measures were promptly implemented for 4 residents (Resident #4, Resident #5, Resident #6 and Resident #7) of 8 residents reviewed for infections, resulting in the potential for the spread of infection to all 56 residents in the facility. Findings include: During the initial tour of the facility on [DATE] at 10:50 AM, with Corporate Clinical Nurse B she was asked for the Infection Prevention and Control Nurse (IC Nurse) and she said (IC Nurse A) had been in the role for approximately 3 months. During a tour of the building, Nurse B said the 400 hall was being used as a monitoring unit for those residents being admitted or readmitted into the facility to rule out respiratory illness, such as Covid-19 (Coronavirus). She said none of the 9 residents on the 400-monitoring hall had signs and symptoms of Covid-19 infection and the 700 hall contained the residents who had tested positive for Covid-19. Four residents were observed residing on the 700 hall Covid-19 unit. Nurse B said there had been 13 residents testing positive for Covid-19, as of [DATE]th, 2020 and 5 of the 13 died . Infection Surveillance documents for March and [DATE] was requested for review. On [DATE] at 10:35 AM, an interview of the facilities process for Infection Prevention and Control with IC Nurse A, Corporate Nurse B and the Administrator was conducted. Infection Control Policies, the Facility Assessment, an Infection Surveillance Plan and Infection Surveillance data, including line listings were requested for March and [DATE]. During the interview, Corporate Nurse B said the IC Nurse was new and Not really performing the Infection surveillance. Nurse B said that the Nurse Managers were helping with that. When asked who the Nurse Managers were, Nurse B said they were off due to Covid-19 illness and the Director of Nursing (DON) was off on a personal leave. Nurse B said the IC Nurse and herself were filling in for the two Nurse Managers. A review of the Infection Surveillance data received from the facility revealed an antibiotic report. There were no residents who had not received an antibiotic. There was only surveillance data for those receiving an antibiotic. Corporate Nurse B was asked if it was an Antibiotic Report and she said Yes. When asked if there was additional surveillance for residents not receiving an antibiotic she said No. When further asked if surveillance was documented based on signs and symptoms of infection the Nurse indicated they collected data based on the antibiotic report. SHEA/APIC (Society for Healthcare Epidemiology of America/The Association for Professionals in Infection Control and Epidemiology) Guideline: Infection prevention and control in the long-term care facility, [DATE] AJIC (American Journal of Infection Control), provided . Because of the impaired immunity of elderly person, [MEDICAL CONDITION] respiratory infections that generally mild in other populations may cause significant disease in the institutionalized patients. Examples include influenza, respiratory [MEDICAL CONDITION] (RSV), parainfluenza, coronavirus, rhinoviruses, adenoviruses and recently discovered human metapneumovirus . Rapid identification of cases in order to promptly initiate treatment and isolate them to prevent transmission remains the key . An outbreak or transmission with in the facility may occur explosively . Outbreaks in LTCF's (Long Term Care Facilities) accounted for a substantial proportion (15%) of reported epidemics . CMS (Centers for Medicare and Medicaid Services) regulations address the need for a comprehensive infection control program that includes surveillance of infections; implementation of methods for preventing the spread of infections including use of appropriate isolation measures . An ICP (Infection Control Practitioner) is an essential component of an effective infection control program and is the person designated by the facility to be responsible for infection control . Infection surveillance in the LTCF involves the systematic collection, consolidation, and analysis of data on HAI's (Healthcare associated infection) . resources that include practice guidance for surveillance identifying seven recommended steps . 1. Assessing the population, 2. Selecting the outcome or process for surveillance, 3. Using surveillance definitions, 4. Collecting surveillance data, 5. Calculating and analyzing infection rates, 6. Applying risk stratification methodology and 7. Reporting and using surveillance information . The surveillance process consists of collecting data on individual cases and determining whether or not a HAI is present by comparing collected data to standard written definitions (criteria) . One recommended data collection method . Walking rounds . collecting concurrent and prospective infection data that are necessary to make infection control decisions . should be done on a timely basis . may use house reports from nursing . chart reviews, laboratory or radiology reports, treatment reviews, antibiotic usage data and clinical observations . On [DATE] at 3:50 PM, the Infection Surveillance documents for March and [DATE], the Facility Assessment and Infection Control Policies were reviewed with Corporate Nurse B and the Administrator. Nurse B said the IC Nurse was not available. Upon review of the document titled Facility Assessment Tool, dated [DATE] and updated [DATE] it read, Nursing facilities will, conduct, document and annually review a facility-wide assessment, which includes both their population and the resources the facility needs to care for their residents . The section for Infection Prevention and Control, provided, Identification and containment of infections, prevention of infections. There was no further information to aid the facility in collecting surveillance data or analysis of identified Infection Control issues. During the interview on [DATE] at 3:50 PM, the policy titled Surveillance for Infections, dated 2001 (MedPass) and revised [DATE] was reviewed with Nurse B. There were no facility staff signatures or recent dates to indicate the policy was reviewed by an Infection Control Nurse or other staff, or when it went into effect. The policy indicated, The Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAI) and other epidemiologically significant infections . that may require transmission-based precautions and other preventative interventions . Nursing staff will monitor resident for signs and symptoms that may suggest infection according to current criteria and definitions of infections and will document and report suspected infections to the Charge Nurse as soon as possible . The Charge Nurse will notify the Attending Physician and the Infection Preventionist of suspected infections . will determine if laboratory tests are indicated and whether special precautions are warranted . The surveillance should include a review of any or all of the following information to help identify possible indicators of infections: . laboratory records, skin care sheets, Infection control rounds or interviews, verbal reports from staff, Infection surveillance sheets, temperature logs, pharmacy records, antibiotic review and transfer log/summary . On [DATE] at 4:00 PM, a review of a document titled, Positive Covid Guest identified 13 residents from [DATE]-[DATE] who tested positive for Covid-19, including Residents #'s 4, 5, 6 and 7. Nurse B was asked the date of the last resident in the facility who tested positive for Covid-19 and said, It is on the document [DATE] (Resident #6). There was no indication of the residents' 1st signs and symptoms of illness (except for Resident #7) or if they were placed in Transmission Based Precautions prior to entering the Covid positive unit. A review of the Infection Surveillance Data for March and [DATE] with Corporate Nurse B during the interview on [DATE] at 3:50 PM indicated several documents including: Infection Control Surveillance for [DATE] that included signs and symptoms of illness, antibiotic/[MEDICAL CONDITION] given and start date. There were 7 residents with symptoms of respiratory illness; 1 with Suspected Influenza with no test result (Flu swab obtained), 1 with Influenza like symptoms, and no Influenza test. Both treated with [MEDICATION NAME]. The other 5 residents were treated with antibiotics with no laboratory tests to identify

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) the infection. The Antibiotic List did not include whether the residents were placed in Transmission Based Precautions to aid in preventing the spread of infection. A review of the [DATE] Infection Surveillance data (antibiotic report) with Nurse B identified 4 large blacked out areas on the document that were not legible. Nurse B was asked about this and said she would provide a clear document for review and it was not received prior to exit on [DATE] at 4:50 PM. The [DATE] Infection surveillance document only included 5 residents with respiratory symptoms and all 5 were Covid-19 positive. The other 8 residents identified with Covid-19 were not listed on the report. The color coded Surveillance Map provided with the document identified 6 residents with respiratory symptoms. The discrepancy between the number of residents the facility identified as Covid- 19 positive (13) on the Positive Covid Guest document, the 5 residents positive for Covid-19 on the [DATE] Infection Surveillance List and 6 residents with respiratory symptoms on the [DATE] Map were reviewed with Corporate Nurse B. She was not able to explain why they did not match/there was inaccurate surveillance data. When asked who was collecting surveillance data, Nurse B said she was. None of the documents indicated if the residents were placed in Transmission Based Precautions. A record review of the Face Sheets, vital signs, physician orders, assessments, progress notes, Minimum Data Set assessments (MDS), Care Plans and documents for Residents #'s 4,5, 6 and 7 revealed the following: Resident #4 The resident was admitted to the facility on [DATE] with Diagnoses: [REDACTED]. The MDS assessment dated [DATE] indicated the resident had a Brief Interview for Mental Status Score (BIMS) of 6 of 15 indicating severe cognitive impairment. Resident #4 needed some assistance with all care. The progress notes indicated on [DATE] a Change of Condition form was completed due to the resident developing a fever of 102.1 F, shortness of breath, blood pressure increased to ,[DATE] weakness, cough, sore throat and a generalized ache, . found shivering in bed . [DATE] . in droplet isolation . moved to room (700 Hall Covid- 19 unit) . A review of the physician orders [REDACTED]. A Care Plan for Covid-19 was dated [DATE] (9 days after symptoms appeared) and Droplet Precautions were added [DATE]. On [DATE] at 10:35 AM, an interview with Corporate Nurse B revealed Resident #4 was still symptomatic with a fever of 99.1 F and oxygen saturation 89% (low). Resident #5 The resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS assessment dated [DATE] revealed a BIMS score of ,[DATE] severe cognitive impairment and resident needed assistance with all care. The resident tested positive for Covid-19 on [DATE]. The progress notes the resident developed a low grade fever 99.0 on [DATE] and 99.1 on [DATE]. The resident's blood pressure increased to ,[DATE] on [DATE]. The resident became weaker and had multiple falls: [DATE], [DATE], [DATE] and [DATE]. On [DATE] Resident #5's temperature increased to 100.5. On [DATE] a note said, . exhibiting symptoms of Covid-19 . moving him to the isolation unit . A physician note dated [DATE] Patient is being seen today . for suspected Covid 19 . complaints of cough . temperature of 100.5 F . and a note . cough that is wet ., [DATE] . continues to refuse water or meds . A review of the orders indicated Droplet Precautions were ordered on [DATE] and a Covid-19 Care Plan dated [DATE]. Resident #6 The resident was admitted to the facility on [DATE] with Diagnoses: [REDACTED]. The MDS assessment dated [DATE] indicated full cognition with a BIMS score of ,[DATE]. The resident needed assistance with all care. A review of the resident's vital signs indicated on [DATE] a fever of 99.4, [DATE] 101.5, [DATE] 99.3, [DATE] 99.9, [DATE] 99.9; Increased heart rate- [DATE] 111, [DATE] 103, [DATE] 102 and [DATE] 138 (normal ,[DATE]). There were only 3 documented respirations in April: [DATE] 18 breaths per minute, [DATE] 20, and [DATE] j both 18 breaths/minute. There was only 1 oxygen saturation rate in April: [DATE] 90% with oxygen via nasal cannula at 2 liters/minute. The resident had a physician's orders [REDACTED]. A review of the progress notes indicated the following: [DATE] at 6:44 PM, Temperature went up to 101.5 F . positive for a UTI (urinary tract infection) . she hurt all over. Tylenol given . temp rechecked and came down to 99.6 . [DATE] at 5:42 AM, . guest reports chills, she is sneezing and has begun coughing. Temp is 98.3 . [DATE] at 7:39 PM, Guest informed that her Covid-19 test result was positive . This was 7 days after the fever spike to 101.5 F. [DATE] Late entry, . cough, fatigue, decreased appetite and chills . [DATE] at 10:08 PM Late entry, . intractable nausea, vomiting and fever. Patient is suspected for coronavirus . [DATE] at 11:04 PM, a progress note indicated Resident #6 was transferred to the hospital. A review of the physician orders [REDACTED]. A review of the Care Plan titled, Actual Infection . was initiated on [DATE] and updated on [DATE] after the resident went to the hospital to indicate she was symptomatic for Covid-19 and tested positive. Respiratory/Droplet isolation, dated [DATE] was listed on the Care Plan, but there was no mention of the precautions in the medical record. On [DATE] at2:40 PM, during an interview with the Clinical Nurse B and IC Nurse A, they were asked about the lack of documentation to indicate when Droplet Precautions were initiated for Resident #6 and why she was not tested sooner for Covid-19 if they suspected she was positive. Neither had a response for this. Resident #7 The resident was admitted to the facility on [DATE] with Diagnoses: [REDACTED]. The MDS dated [DATE] indicated the resident had severe cognitive loss/BIMS ,[DATE] and needed assistance with all care. A review of the vital signs revealed the following; A high blood pressure reading on [DATE] of ,[DATE] then low blood pressure; [DATE] ,[DATE], [DATE] ,[DATE] The resident had high blood pressure again on [DATE] ,[DATE]. Temperature: [DATE] 101.7, [DATE] 97.3 and [DATE] 99.4. Pulse: Low on [DATE] at 56 beats/minute. The resident received oxygen and on [DATE]-[DATE] the oxygen saturation readings were 90%-95%. A review of the progress notes revealed the following: [DATE] at 12:03 PM, . 2 falls overnight . hypotensive (low blood pressure) . oxygen saturation 92%, 02 2/L nasal cannula . productive cough . temperature of 102 . [DATE] at 6:45 PM, . adventitious lung sounds in left upper lobe and increased temperature . oxygen saturation began to drop 88% . wheezing . [DATE] 6:04 PM, . has loose stool that was blood tinged . [DATE] at 4:03 PM, . complains of general all over body aches . [DATE] physician note, . wet cough . guest yelling out in pain. A Covid test was recommended . A review of the physician orders [REDACTED]. A review of the physician orders [REDACTED]. The resident had been symptomatic for Covid-19 since [DATE]. A review of the Respiratory Care Plan for Resident #7 indicated no mention of Droplet Precautions. During the interview with the Corporate Nurse B and IC Nurse A on [DATE] at 2:40 PM, they were asked why there was inconsistency in initiating Transmission Based Precautions, obtaining physician orders [REDACTED]. Surveillance of signs and symptoms of infection was again reviewed with Nurse B and IC Nurse A, as they had indicated they were relying on antibiotic administration instead of signs and symptoms of illness to track infections. Nurse B reiterated that IC Nurse A had only been in her role for 3 months and Nurse B was helping with surveillance.