| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235612 | A. BUILDING _____ B. WING _____ | 07/09/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **FREEMAN NURSING & REHAB COMMUNITY** | **1805 PYLE DRIVE KINGSFORD, MI 49802** |

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) |
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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to maintain infection control practices during a Focused COVID-19 Infection Control Survey by: 1) failure to prevent the potential for cross contamination between quarantine and non-quarantine residents, 2) failure to follow the Centers for Disease Control and Prevention (CDC) guidance for preservation of Personal Protective Equipment (PPE), 3) failure to follow facility policy and CDC Guidance for use of appropriate PPE in quarantine rooms, 4) failure to practice appropriate hand hygiene during cleaning and disinfection of quarantine areas, 5) failure to implement transmission-based precautions for residents exposed to COVID-19. This deficient practice resulted in the potential for transmission of COVID-19 (a highly transmissible [MEDICAL CONDITION] infection) for all 39 vulnerable residents residing in the facility. Findings include: All recorded times reflect Eastern Standard Time (EST). An interview with the Nursing Home Administrator (NHA) on 7/8/20 at 9:10 a.m., revealed one Resident (#1) in the facility had tested positive for Covid-19 on 7/7/20. The NHA reported upon notification of the positive test result, Resident #1 had been relocated to a private room and was placed in transmission-based precautions. An interview with the Director of Nursing (DON) on 7/8/20 at 9:15 a.m., revealed upon testing positive for COVID-19, Resident #1 had been moved to room [ROOM NUMBER], a private room, from room [ROOM NUMBER], which they had shared with Resident #2. The DON reported<br>Resident #1 and Resident #2 were placed in droplet precautions immediately upon notification of Resident #1 testing positive for COVID-19. In addition to Resident #2, all new admissions and re-admissions were placed in quarantine, using droplet precautions, for 14 days from time of admission, to monitor for signs and symptoms of COVID-19. There were six new admissions in quarantine at the time of the survey. 1) An observation of the South Hall, on 7/8/20 at 9:25 a.m., revealed a PPE bin located in the hallway outside of room [ROOM NUMBER]. Signs posted on the wall near the doorway indicated staff were to use droplet precautions when entering the room. The name plaques for room [ROOM NUMBER], indicated Resident #1 and Resident #2 shared the room. Further observation revealed Resident #1 and resident #2 shared a bathroom with the two residents residing in room [ROOM NUMBER]. The bathroom had a door on each side to allow access from either room. An observation of the hallway outside of room [ROOM NUMBER], revealed no PPE bin or signs indicating the residents in room [ROOM NUMBER] were in droplet precautions. An interview with Certified Nurse Aide (CNA) E at the time of the observation, revealed Resident #1 had tested positive for COVID-19 and was moved to a private room on the West Hall. CNA E confirmed Resident #2 was in droplet precautions due to exposure to COVID-19 due to Resident #1 testing positive while sharing the room. CNA E also confirmed the room belonging to Resident #2, and previously Resident #1, shared a bathroom with the two residents in room [ROOM NUMBER]. When asked who was responsible for disinfecting the resident's shared bathroom, CNA E reported housekeeping cleaned the bathrooms. CNA E reported the two, residing in room [ROOM NUMBER], were not in droplet or any type of transmission-based precautions. An observation of the West Hall, on 7/8/20 at 10:23 a.m., revealed no signs upon entering the open hallway, indicating the hall housed COVID-19 positive residents. There were PPE bins located outside of rooms #103, #106, and #111. Signs located outside the rooms indicated the residents residing in the rooms were in droplet precautions. Further observation revealed the residents in quarantine and droplet precautions shared adjoining bathrooms, as follows: room [ROOM NUMBER] shared with #104; room [ROOM NUMBER] shared with #107, and room [ROOM NUMBER]<br>shared with #110. An interview with Licensed Practical Nurse (LPN) H, revealed the residents residing in rooms #103, #106 and #111, were quarantined and in droplet precautions to be monitored for signs and symptoms of COVID-19. LPN H reported droplet precautions were not being used for the residents in the respective adjoining rooms, #104, #107 and #110. When asked who was responsible for cleaning the bathrooms, LPN H reported she kept disinfecting wipes on her medication cart to use to wipe down the surfaces of the room before leaving upon completion of care. When asked to view the container of wipes, LPN H reported they did not have any wipes on their cart at that time. LPN H left to retrieve disinfecting wipes from the DON's office. An observation on 7/8/20 at 10:28 a.m., revealed CNA F exit the West Hall, where Resident #1 resided, and enter the South Hall. CNA F immediately began going from room to room retrieving the finished breakfast trays from the resident's rooms. An interview at the time of the observation revealed CNA F had been floating between halls to assist with resident care. CNA F reported they had assisted in the care of Resident #1, on the West Hall, earlier that morning, by getting the resident up from bed. When asked if they were aware Resident #1 had tested positive for COVID-19, CNA F reported she was aware of the resident's status. When asked what the procedure was for floating between halls when caring for a resident with COVID-19, CNA F reported she was scheduled to work on one hall and often, floated, to the other hall to help out. An observation on 7/8/20 at 11:04 a.m., revealed Registered Nurse (RN) B, donned in PPE, administering medications to Resident #2. Upon completion, RN B exited the room, without disinfecting any surfaces inside the resident's room. In an interview immediately following the observation, RN B confirmed Resident #2 was in droplet precaution due to recent exposure to COVID-19. When asked about disinfection of the isolation room, RN B reported housekeeping was responsible for cleaning and disinfecting the isolation rooms, including the bathroom shared with the residents who were not in isolation. An interview with the DON on 7/8/20 at 3:00 p.m., revealed the quarantined residents were in droplet precautions and were being treated as, COVID-19 positive, due to the risk of possible exposure prior to admission to the facility. The DON confirmed the residents in quarantine and droplet precautions in rooms #103, #106, #111 and #118 shared adjoining bathrooms with non-quarantined residents. The DON agreed there was a concern of possible cross-contamination with quarantined residents and through staff utilization of the bathrooms shared with non-quarantined residents. The DON reported that staff, know to wipe it down. A review of the facility assessment, dated 11/21/17, revealed the assessment had not been updated to include information and planning for the occurrence of COVID-19, including the utilization of dedicated staff in the care of residents with COVID-19 or where in the building residents with COVID-19 and newly admitted , quarantined residents would be placed. A review of the policy, titled, 2019 Novel Coronavirus (COVID-19), dated 5/2020, revealed the following, in part: Admissions: .All residents admitted should be placed in Standard, Contact and Droplet Precautions and be closely monitored in a private room if possible and, if not, with a resident with a like [DIAGNOSES REDACTED]. place with resident in a single-person room or separate observation area so the resident can be monitored for evidence of COVID-19. A review of the CDC guidance, titled, Responding to Coronavirus (COVID-19) in Nursing Homes, updated 4/30/20, revealed the following, in part: Determine the location of the COVID-19 care unit and create a staffing plan before residents or HCP with COVID-19 are identified in the facility. This will allow time for residents to be relocated to create space for the unit and to identify HCP to work on this unit . Assign dedicated HCP to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents . Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19. In an interview on 7/9/20 at 11:50 a.m., the NHA confirmed the facility assessment had not been updated to address the COVID-19 pandemic. The NHA reported the question of updating the facility assessment, to include the facility's plan for admissions and housing of COVID-19 positive residents, was being addressed, by QA (quality assurance), that morning (7/9/20). 2), 3) & 4) |

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<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | (continued... from page 1)<br>An observation on 7/8/20 at 9:30 a.m., revealed signs posted outside Resident #2's room (#118) indicating the resident was in droplet precautions. A PPE bin was in the hallway directly next to the door of the room. Sitting on the top of the PPE bin were five open, brown paper bags, each bag had a name written on the outside. Further observation revealed N95 respirator masks in all five of the bags. Three of the bags containing respirators also contained yellow isolation gowns that had been bunched up next to the respirators inside the bags. An interview with CNA E, who was present at the time of the observation, revealed the gowns and respirators inside the bags were worn and placed in the bags for preservation and reuse by staff. An interview with Registered Nurse (RN) B on 7/8/20 at 9:40 a.m., revealed Resident #2 was in quarantine and droplet precautions due to his recent roommate testing positive for COVID-19. An observation on 7/8/20 at 1033 a.m., revealed a PPE bin located in the hallway outside of room [ROOM NUMBER], belonging to Resident #4 and Resident #5. A sign next to the door indicated the residents were in droplet precautions. Further observation revealed a stand inside the room to the right of the door. The stand held paper bags with names written on the outside. Inside the open bags were N95 respirators with names written on the outside of the bags. An interview with the DON on 7/8/20 at 1100 a.m., revealed Resident #4 and Resident #5 were new admissions in quarantine to monitor for signs and symptoms of COVID-19. When queried about the bags observed on the table inside the resident's room, the DON reported the paper bags were to preserve the N95 respirators for reuse by staff providing care to the residents. The DON confirmed staff donned the N95 masks after entering the resident's care area by removing their surgical mask and replacing it with the N95 mask. An observation on 7/8/20 at 11:04 a.m., revealed RN B inside Resident #2's room, wearing an isolation gown, gloves, glasses and an N95 respirator mask. Upon leaving the room, RN B removed the soiled gown and gloves and placed them in the trash receptacle located in Resident #2's room. RN B then performed hand hygiene with the alcohol based hand rub immediately outside the room, removed the N95 respirator and by placing the mask in their right hand, bunched the mask up by closing their hand in a fist over the outside of the mask then placed the mask into the left pocket of their uniform shirt. During an interview at the time of the observation, RN B was asked if they kept the mask inside a bag for preservation and reuse, RN B reported they kept the mask in their pocket while they worked. RN B did not perform hand hygiene after touching the outside of the mask and placing the mask in their pocket. An observation on 7/8/20 at 11:20 a.m., revealed Housekeeping Staff K standing in the doorway of Resident #2's room, wearing a gown, gloves, glasses and a surgical mask. Staff K was asked at the time of the observation, what type of mask she had been instructed to wear in the isolation room. Staff K replied they had not been issued any other type of mask. Staff K was asked if she had an N95 respirator mask, to which they reported they did not know what an N95 mask was. Staff K then began opening three clear plastic bags and hung the bags from the housekeeping cart. Staff K proceeded to remove a spray bottle of disinfectant and clean rag from the cart and entered Resident #2's room. Staff K was observed wetting the clean rag in the sink, then spraying the sink and counter with disinfectant, and wiping down the sink and counter with the rag. Upon completion of cleaning the bathroom, Staff K entered the doorway of Resident #2's room, reached out onto the cart located in the hall and placed the soiled rag in one of the clear bags hanging on the cart. Staff K then reached on top of the cart without removing the soiled gloves, to grasp a roll of paper towel, proceeded remove sheets of paper towel from the roll and replaced the remainder of the roll back on top of the cart. Staff K then proceeded back into Resident #2's room, retrieved the bottle of disinfectant from the bathroom counter, proceeded to spray the paper towel with disinfectant which they used to wipe down the stand and table in front of the window, then placed the bottle of disinfectant on the wheeled stand near the window. After wiping down the surfaces in the room, Staff K removed their gloves, and without performing hand hygiene, retrieved the bottle of disinfectant from the stand inside the resident's room and placed the bottle in the cart located in the hall outside the resident's room. Staff K walked out of the quarantine room without removing the soiled gown and proceeded to walk around the cart, to the middle of the hallway, to retrieve the mop located on the outside of the housekeeping cart. At that time, Staff K reported to this Surveyor they knew they should not be leaving the isolation room wearing the soiled PPE, but it is impossible not to. Staff K then, with ungloved hands, reached into the bucket containing mop rags soaked in disinfectant, rang out the excess liquid into the bucket and proceeded into the room, placed the rag on the mop and began mopping the floor. Staff K then removed the soiled mop rag with bare hands and placed the rag into a clear bag hanging on the cart. Without performing hand hygiene or donning gloves, Staff K reached into the bucket of clean mop rags, retrieved another rag, wrung out the excess liquid into the clean rag bucket and proceeded back into the isolation room. When finished, Staff K, with ungloved hands, removed the soiled mop rag from the mop, approached the cart in the hallway and proceeded to walk back around the cart in the hallway to replace the mop. Without performing hand hygiene, Staff K retrieved the roll of paper towel from on top of the cart, removed a few sheets and went back into the isolation room where she washed her hands in the bathroom sink, dried her hands with the paper towel then upon exiting the room, bent down to pick up a piece of debris from the floor with ungloved hands. Staff K then discarded the debris and used paper towel in the trash receptacle located on the cart in the hallway and left the room while still wearing the soiled isolation gown. At that time, Staff K was alerted by this Surveyor of the fact she was still wearing the gown she had worn in the isolation room. Staff K replied, I forget sometimes. Staff K removed the gown, walked back into the isolation room, discarded the soiled gown with ungloved hands and exited the room without performing hand hygiene. Further interview at that time revealed Staff K was unaware she had not performed hand hygiene and of the need to disinfect the housekeeping cart prior to using it again. Staff K immediately performed hand hygiene and left the floor, accompanied by this Surveyor, to complete disinfection of the housekeeping cart. An observation on 7/8/20 at 12:00 p.m., revealed a stand positioned inside the doorway of Resident #1's room. On top of the stand were several brown, paper bags with names written on the outside, housing N95 respirators. Housekeeping Staff C who was present at the time of the observation, revealed Resident #1 was in droplet precautions due to testing positive for COVID-19. An interview with the DON on 7/8/20 at 3:00 p.m., revealed the brown paper bags observed inside the isolation rooms, including the room belonging to Resident #1, were used to hold N95 respirators for reuse by staff. The DON reported several of the residents residing in the facility, wandered, therefore they felt it more appropriate to keep the PPE out of the hallway. The DON agreed there was a concern with contamination of the PPE housed inside the isolation rooms as well as a risk of exposure due to staff donning and doffing masks inside the rooms with the positive COVID-19 resident and the quarantined residents. When queried as to whether staff should house their N95 masks for reuse in their pockets, the DON reported staff should utilize the paper bags for preservation of their N95 masks. A review of the policy titled, 2019 Novel Coronavirus (COVID-19), dated 5/2020, revealed the following, in part: Strategies for Potential PPE Shortages . strategies are available on the CDC website dedicated to optimizing the supply of PPE . A review of the facility policy titled, Hand Washing/Hand Hygiene, dated 4/2020, revealed the following, in part: [MEDICATION NAME] hand hygiene is a simple effective way to prevent infections by preventing the spread of germs. Wash hands and other skin surfaces when: 1. After immediate contamination with blood, other body fluids or potentially contaminated articles; 2. After removing gloves or other personal protective equipment. A review of the CDC guidance titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 7/9/2020, revealed, in part: Disposable respirators and facemasks should be removed and discarded (unless extended use or reuse) after exiting the patient's room or care area and closing the door .perform hand hygiene after removing the respirator or facemask. A review of the CDC guidance, titled, Recommended Guidance for Extended Use and Limited Reuse of N95 Filtering Facepiece Respirators in Healthcare Settings, dated 3/2020, revealed the following, in part: Hang used respirators in a designated storage area or keep them in a clean, breathable container such as a paper bag between uses . avoid touching the inside of the respirator. If inadvertent contact is made with the inside of the respirator, discard the respirator and perform hand hygiene as described above. A review of the CDC guidance titled, Preparing for COVID-19 in Nursing Homes, updated 6/25/20, revealed the following, in part: Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator. 5) During the review of the facility infection surveillance, on 7/8/20, at approximately 1:00 p.m., the DON reported two staff members had tested positive for COVID-19. Review of the test result for Physician I revealed they had been tested for COVID-19 on 7/2/20, with a positive test result reported on 7/4/20. A review of the contact tracing provided by the NHA on 7/9/20 at 10:41 a.m., revealed 10 residents were exposed to Physician I on 7/2/20. At the time of the survey, six of ten of the residents were not in quarantine for exposure to the positive COVID-19 physician. Review of the test result for CNA J revealed CNA J had been tested for COVID-19 on 7/3/20 with a positive test result reported on 7/7/20. The DON reported CNA J had worked after being tested for COVID-19 and prior to receiving notification of the positive result. The DON was unsure what dates the resident had worked. Review of the staff surveillance record, revealed a listing for CNA J included the following, in part: Onset: 7/3/2020 . Last worked: 7/7/2020. When asked what residents had been exposed to CNA J, the DON reported CNA J had |

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| | **235612** | A. BUILDING _____ B. WING _____ | **07/09/2020** |

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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | (continued... from page 2)<br>worked closely with, all of the residents on the West Hall. When asked why the residents on the West Hall were not in quarantine to monitor for signs and symptoms of COVID-19, the DON reported all of the residents had been tested at the same time as CNA J and all had tested negative for COVID-19. According to the DON, all testing had been completed as of 7/3/2020. A review of the employee data for CNA J, provided by the NHA on 7/9/2020 at 10:41 a.m., revealed CNA J had worked on the West Hall on 7/4/20, 7/5/20, 7/6/20 and 7/7/20, all following testing on 7/3/20. As of the end of the survey, 10 of the 17 residents residing on the West Hall were not in droplet precautions. On 7/9/20 at 11:52 a.m., the DON confirmed there was a concern for transmission of COVID-19 from CNA J to the residents on the West Hall, as well as to the residents that had been in contact with Physician I. When asked why the West Hall had not been completely quarantined due to exposure to CNA J or the residents seen by Physician I, the DON reported they did not feel it necessary to place all of the exposed residents in quarantine and droplet precautions as the facility would be conducting weekly testing for COVID-19. A review of the CDC guidance, titled, Responding to Coronavirus (COVID-19) in Nursing Homes, updated 4/30/20, revealed the following, in part: Residents who were cared for by these HCP (positive for COVID-19) should be restricted to their room and be cared for using all recommended COVID-19 PPE .If the HCP is diagnosed with [REDACTED]. |