| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235551 | A. BUILDING _____ B. WING _____ | 07/30/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| GREENTREE OF HUBBELL REHAB AND HEALTH | 52225 B AVENUE HUBBELL, MI 49934 |

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<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 perform adequate hand hygiene and ensure the proper donning, doffing, cleaning, storage, and disposal of Personal Protective Equipment (PPE) used during provision of care to four Residents (#2. #3, #4, and #5), out of five residents reviewed during a COVID-19 Focused Infection Control survey. This deficient practice resulted in the potential for transmission of COVID-19 (a highly contagious respiratory virus) to all 32 vulnerable residents. Findings include: On 7/28/20 at 11:30 a.m., during entrance screening, Staff D was observed wearing a facemask which was not molded tightly to nose or face, that dropped below her nose during this Surveyor's facility entrance screening. On 7/28/2020 at 12:45 p.m., the Nursing Home Administrator (NHA) confirmed there were four Residents in 14-day quarantine for new admission, readmission, or close contact with COVID-19 positive staff. The NHA accompanied this Surveyor to observe the following new admission/readmission quarantine rooms: 1. The NHA knocked on Resident #4's door, and Certified Nurse Aide (CNA) I opened the door wearing goggles, and a KN95 mask hanging off her right ear, the elastic on the left side hanging loosely near the front of her face, not secured to her left ear at all. The mask appeared ready to fall off her face. CNA F was observed inside Resident #4's room wearing goggles and a KN95 mask. 2. Resident #3 had a clean shirt on a hanger hung from the hall railing, laying directly on the PPE storage cart outside the room. When asked about the placement of the shirt, the NHA stated, No, it (shirt) shouldn't be there. 3. Resident #5 had a piece of apple pie on a plastic plate sitting on top of the PPE storage cart outside the room. The NHA removed the pie from the top of the PPE storage cart and placed it inside the dirty meal tray cart. 4. Resident #2's door was shut. Review of the CDC Preparing for COVID-19 in Nursing Homes, Updated June 25, 2020, revealed the following, in part: .Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown . HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or face shield that covers the front and sides of the face), gloves, and gown when caring for these residents . During an observation/interview on 7/28/20 at approximately 12:55 p.m., Staff S was wearing goggles and a KN95 facemask while mopping resident rooms. When asked how often her KN95 facemask was changed, Staff S said the facemask had not been changed all day. Staff S confirmed she had worn the same facemask and goggles into both quarantine and non-quarantine rooms. During an interview on 7/28/20 at approximately 1:00 p.m., with the NHA present, Staff M was asked about wearing the same facemask into all facility rooms, including the quarantine rooms. Staff M stated, We are supposed to cover the KN95 mask with a surgical mask when we go into the quarantine rooms. The NHA stated, Yes, that (covering KN95 with surgical mask for quarantine rooms) is what we are doing. When asked if the staff in Resident #4's rooms (CNAs I and F) had their KN95 masks covered with a surgical mask, as previously observed with the NHA, the NHA confirmed they had not been wearing a surgical mask over their KN95 masks. During an interview on 7/28/20 at 1:29 p.m., the Director of Nursing (DON) was asked about the use of facemasks in quarantine rooms. The DON stated, They (staff) are wearing their KN95 into the quarantine rooms as well as the other resident rooms then paused and stated, I don't know what they are doing right now During an interview on 7/28/20 at 1:53 p.m., when asked about facemasks, Staff G stated, Everybody was instructed to wear the surgical mask over the KN95 mask today, since you (this Surveyor) have been here. It was passed on (by) word of mouth by Staff H. Before today I wore the KN95 mask in (to quarantine rooms) without the surgical mask . During an interview on 7/28/20 at 2:01 p.m., Staff H confirmed reuse of the same KN95 mask and goggles for three working days. Staff H stated, I keep the mask on me, in my car, as well as my goggles, in a bag. We do have lockers if need be. There is storage at the door (entrance screening door) if we wanted to leave our bag (of potential contaminated PPE) in that box up to three days .I am aware that we can take our used PPE with us. When asked if there was any concern with taking dirty PPE out of the facility, Staff H stated, If there was anything (infectious organisms/bacteria) on the mask, there is definitely a problem with taking it to my car. During an interview on 7/28/20 at 2:08 p.m., Staff I confirmed her mask had come off her ear during the previous observation inside Resident #4's room door. Staff I said her KN95 masks came off regularly because she has small ears, and said she needed a mask with elastic around her head. On 7/28/20 at 2:55 p.m., Staff W was observed sitting at the break room table reading, with her facemask under her chin. An unidentified staff person was standing next to the break room table, without adequate social distancing (6 feet). Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, Updated July 15, 2020, revealed the following: .HCP (Health Care Providers) should wear a facemask at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers .HCP who enter the room of a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator (or facemask if a respirator is not available), gown, gloves and eye protection . On 7/29/20 at 8:10 a.m., CNA J was observed standing inside the open doorway of Resident #5's room wearing goggles and a KN95 facemask. CNA J removed the goggles and placed them on top of Resident #5's PPE storage cart. CNA J removed the KN95 mask - placing it directly on top of the PPE cart, donned a new/clean KN95 mask, then picked up the dirty KN95 facemask from the top of the cart with bare hands, rolled it up and placed the dirty KN95 in a scrub pants pocket. CNA J used bare hands to open the PPE cart drawers without hand sanitation, retrieved a gown, and face shield. CNA J donned the new PPE, including gown, face shield, and gloves without hand sanitation, and entered Resident #5's room. The dirty goggles remained in the hallway, on top of the PPE cart. CNA J exited Resident #5's room at 8:23 a.m., with all PPE removed, except for the face shield and the KN95 facemask. CNA J then removed the face shield, placed it with the outside of the face shield directly on the surface of the PPE storage cart, and donned his previously used goggles without hand sanitation. The used KN95 mask was removed, placed on top of the PPE cart. CNA J retrieved and donned a new KN95 mask from the PPE cart. CNA J picked up the KN95 mask used in Resident #5's quarantine room and roll it up in the left hand and began to place the mask in the scrub pants pocket. During an interview at this same time, when asked about disposal of the facemasks, CNA J stated, I have a couple other masks in my pocket. CNA J pulled them out (appeared to be two masks and a couple of gloves) of the scrub pocket with bare hands, showed them to this Surveyor, and walked down the hall, leaving the dirty face shield on top of the PPE cart. Review of the CDC Preparing for COVID-19 in Nursing Homes, Updated June 25, 2020, revealed the following, in part: .Care must be taken to avoid touching the respirator, facemask, or eye protection. If this must occur (e.g., to adjust or reposition PPE), HCP should perform hand hygiene immediately after touching PPE to prevent contaminating themselves or others . On 7/29/20 at 8:20 a.m., CNA H donned shoe coverings, and without hand sanitation donned an isolation gown, snapping it closed in the front, rather than the back. Gloves were donned. A surgical mask was used to cover the KN95 mask worn all shift. Her gloved fingers touched her hair as she placed the loops behind her ears. At 8:22 a.m., CNA H exited Resident #5's room wearing the same goggles used all shift, the KN95 mask, with all other PPE removed inside the room. No sanitation of CNA H's goggles was observed prior to or following exit from Resident #5's room. On 7/29/20 at approximately 8:24 a.m., CNA H cleaned CNA J's dirty face shield with bare hands and two hand wipes taken from Resident #2's PPE Storage bin. The face shield was not allowed to dry but placed directly into the top drawer of |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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>Resident #5's PPE storage cart, touching the interior surface of the drawer, stethoscope and other supplies. Review of the wipes used to cleanse CNA J's face shield, revealed the following: (Name Brand) Antimicrobial Hand Wipes .for handwashing to decrease bacteria on skin when soap and water is not readily accessible . No effectiveness against Coronavirus was listed, nor was a kill time noted on the label. Review of the undated Droplet Precautions policy revealed the following: 1. Droplet precautions will be implemented for residents with suspected Coronavirus, COVID-19 for 14 days. Residents are suspected of Coronavirus, COVID-19 if they are newly admitted , returning admissions, returning from the emergency room . 5. Staff will don appropriate PPE when entering the room of a resident with suspected or confirmed Coronavirus, COVID-19. When leaving the resident's room, the PPE will be disposed in a wastebasket outside the room, and staff will perform hand hygiene . During an interview on 7/29/20 at 8:27 a.m., CNA J was asked to show this Surveyor where the dirty KN95 masks, retrieved from the scrub pants pocket, were thrown away. CNA J walked into the B Hall Soiled Utility Room, and lifted the cover on the second large, black garbage can against the wall, bypassing the first garbage can. The bottom had several individual gloves, but no other garbage was present in the can. CNA J stated, They must have taken it (garbage). After this Surveyor requested to look inside the first garbage can, CNA J lifted the lid revealing a black garbage bag, lying partially open inside the garbage can. On top of the plastic bag edges, more than half-way down inside the can were multiple KN95 masks, and gloves. CNA J attempted to pull the plastic bag up onto the edges of the garbage can, but it did not fit. CNA J use bare hands to pick up the contaminated KN95 masks, gloves, and other waste, and place them into the held open bag. CNA J did not wash hands, nor perform any hand sanitation prior to closing the garbage can, touching the door handles, door edges, and returning to the facility floor. On 7/29/20 at 8:35 a.m., Staff X was observed standing at the nurse's station without goggles or face shield. On 7/29/20 at 8:40 a.m., Staff Q was observed touching/adjusting the front of her face mask with her bare left hand. Staff Q entered the code for the kitchen door, entered the kitchen and began working without any hand sanitation. On 7/29/20 at 8:45 a.m., the B Hall Storage Room was observed in the presence of Staff M. Two previously used/dirty face shields were found on the counter, one with a staff name, one unidentified. Staff M stated, I would think these are dirty. They should go to a Sanitize Me Box . I don't know why this is here .Only thing here should be clean. Staff M picked up the dirty face shields with bare hands. On 7/29/20 at 8:50 a.m., previously used KN95 masks were observed in an open cardboard box immediately inside the COVID-19 staff/visitor screening room, along with another box for goggles. When asked about the storage of used PPE, Staff U confirmed dirty goggles went into a box right at the entrance screening, and used (and saved for reuse) KN95 facemasks were placed in sealed plastic sandwich bags until next used. Staff U confirmed she was responsible for cleaning and disinfecting the goggles prior to their next use. Staff U was observed pulling her KN95 facemask outward, and down below her nose in the entrance screening room. When asked about having her nose uncovered by the mask, Staff U stated, I had to breathe for a second. Review of the facility 2019 Novel Coronavirus (COVID-19) policy, dated 5/2020, revealed the following, in part: HCP (Health Care Providers) must take care not to touch their eye protection and respirator or facemask . During an interview on 7/29/20 at 9:00 a.m., when asked about any concern with storing a previously used, moist (from breathing) KN95 facemask in a sealed plastic bag, the DON stated, It would have more bacteria. During an interview on 7/29/20 at 9:05 a.m., when asked about the storage of previously used KN95 facemasks in sealed plastic bags at the entrance screening area, Registered Nurse/Infection Control (Staff) B stated, .Moisture stays - bacteria would grow . When asked about removal and storage of dirty PPE immediately inside the entrance of the visitor/staff COVID-19 screening room, Staff B stated, There should be a separate door (for staff exit and PPE removal), otherwise (there is a) possibility of cross-contamination . During an interview on 7/29/20 at 9:15 a.m., when asked about storage of PPE for future use, Staff R stated, I take the goggles and facemask (with me) when I leave. I stick them in a Ziploc baggie. Review of the CDC Strategies for Optimizing the Supply of Facemasks, Updated June 28, 2020 revealed the following: .HCP should leave patient care area if they need to remove the facemask. Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folder mask can be stored between uses in a clean sealable paper bag or breathable container . On 7/29/20 at 9:31 a.m., Staff L was observed to enter and exit Resident #3's quarantine room with the same goggles as worn into non-quarantine rooms. When asked about the use of the same goggles, Staff L confirmed she was aware goggles were supposed to be changed when entering a quarantine room. During an interview on 7/29/20 at 9:45 a.m., in the presence of the DON, NHA, and RN/IC M this Surveyors observations and interviews were discussed, including the following: 1. When asked about staff placing previously used (soiled) goggles and used KN95 masks directly on PPE storage carts in the hallway, the NHA confirmed it was not acceptable practice. The NHA said soiled KN95 masks should go into the soiled utility room, into a red bag, and confirmed it was not acceptable to roll up used KN95 facemasks and place them in a clothing pocket. 2. The NHA also indicated isolation gowns should be closed in the back to prevent opening in the front with potential exposure in the quarantine/isolation rooms. 3. The NHA stated, No, the goggles should not go in and out of quarantine rooms. 4. When asked about reaching into a dirty garbage can with bare hand, touching soiled KN95 masks, all present agreed gloves should have been donned prior to touching garbage, and hand hygiene performed prior to exiting the room. 5. When asked about the use of the (Name Brand) Antimicrobial Hand Wipes for cleaning and disinfecting of face shields, all present agreed that product was not intended for disinfecting medical equipment, and medical equipment used within quarantine rooms should be cleaned by the individual who had worn the face shield. 6. The NHA confirmed all facility staff, including the bus driver, were required to don the same PPE, including goggles or face shield and face mask. 7. The NHA confirmed if staff touched the front of their face mask, hand hygiene was required. 8. All present agreed used (dirty) PPE should not be removed from the building, but either disposed of, or saved for reuse prior to exiting the building. |
| F 0885<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | Based on interview and record review, the facility failed to ensure that all Residents and Resident Representatives were notified of positive COVID-19 test result for staff members. This deficient practice resulted in residents and resident representatives being unaware of the potential for increased spread of COVID-19 within the facility, and had the potential to affect all 32 vulnerable facility residents. Findings include: During an interview on 7/28/20 at 2:20 p.m., when asked about notification to all residents/resident representatives regarding the staff that had tested positive for COVID-19, Social Worker Designee (Staff) N indicated documentation of the telephone contact or personal notification to residents would be in the resident progress notes. Staff N stated, Yes, you will see that I notified all residents of the positive staff members. When asked about progress notes for notification of cognitively intact residents, Staff N said nursing staff was responsible for their notification. When asked if there would be a progress note completed by the nursing staff, Staff N stated, I am not sure - but there should be. Review of progress note completed by Staff N, detailing telephone contact with Resident Representatives and Emergency Contacts revealed the only information present was the request for verbal telephone consent for COVID-19 testing of 18 of the 32 residents. When asked again about documentation to show all residents/resident representatives were contacted, Staff N stated, No, you will not find evidence of that notification anywhere. Review of the facility Reporting Requirements for COVID 19 results with employees or residents, undated, revealed the following: .Results (COVID-19 test) will be communicated to residents as soon as possible upon receiving results. Results will be communicated to DPOA (Durable Power of Attorney) and/or Responsible party upon return tests as soon as possible. Results will be reported to the Health Department upon return of tests as soon as possible. Reports if 3 residents have respiratory signs/symptoms at the same time to Health Department . Review of The Centers for Medicaid and Medicare Services (CMS) regulation pertaining to COVID-19 reporting revealed the following: The facility must . Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must . Not include personally identifiable information . Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and . Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. Review of Resident #1's, #2's, #3's, #4's, and #5's Minimum Data Set (MDS) assessments, revealed Resident #1, #2, #3, and #5 were cognitively intact based on their Brief Interview for Mental Status (BIMs). Review of their medical records, including nursing and social service progress notes found no documentation that these four residents had been informed of newly confirmed COVID-19 positive staff members. Review of Resident #4's progress notes revealed the following: 7/20/20 16:57 (4:56 p.m.): I received verbal telephone consent from (Name), POA/responsible party, to perform repeat COVID-19 testing. 7/22/2020 15:26 (3:26 p.m.): DPOA-care |

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| F 0885<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 2)<br>consents to weekly COVID-19 testing and would like to be notified of results each test. During a telephone interview on 7/29/20 at 3:35 p.m., Resident Representative V was asked about notification of positive staff members within the facility. Resident Representative V was unable to tell me when she was informed of the positive cases, but said she was aware the facility did have positive staff. Resident Representative V asked, Are they (facility staff) allowed to tell me if they have any new (staff/residents) positives? I called there (to the facility) and they (nursing staff) said they could not give me that information. That was concerning because I want to know what is happening there. During an interview on 7/29/2020 at approximately 10:20 a.m., the Nursing Home Administrator (NHA) was asked about completion of family notification to all residents and resident representatives. The NHA stated, We just had (Staff N) doing it (notifying resident representatives). (Staff N) will document on a sign-in sheet and document in the future. The NHA expressed understanding of this Surveyor's concern. |