STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235025	A. BUILDING _____ B. WING _____	04/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEADOW BROOK MEDICAL CARE FACILITY	4543 SOUTH M-88 HIGHWAY BELLAIRE, MI 49615

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.** Based on observation, interview and record review, the facility failed to properly maintain infection control practices during a COVID-19 Infection Control Survey by failing to screen employees for signs, symptoms, and exposure to COVID-19 (a highly transmissable infection), and failure to implement employee source control (masking), prior to entering the facility. This deficient practice resulted in the potential transmission of COVID-19 to all 110 residents living in the facility. Findings include: On 4/17/20 at 11:05 a.m., an observation at the designated employee entrance to the facility revealed a screening station equipped with a thermometer, hand sanitizer, bleach disinfectant wipes, and a green file folder containing yet-to-be-completed forms titled, Employee - Coronavirus Screening Form. An observation of the Orchard Hill Unit, on 4/17/20 at 11:50 a.m., revealed the following layout: upon entrance to the unit, the living area was on the left with the dining and kitchen areas on the right. The dining and kitchen serving areas were divided by a bar-type counter with seating which faced the kitchen serving area. A high counter separated the kitchen serving area from the hallway leading to the resident's rooms. Access to the high counter could be gained from both the kitchen serving area and hallway. Observed on the high counter was a bottle of hand sanitizer, a thermometer, surgical masks and a green file folder. Two residents were in the living area across from the kitchen at the time of the observation. An interview with Certified Nurse Aide (CNA) C, on 4/17/20 at 12:00 p.m., revealed they regularly worked on the Orchard Hill Unit. CNA C reported undergoing screening for COVID-19 upon presenting for work each day they was scheduled. When asked if they was screened for COVID-19 at the employee entrance to the facility, CNA C replied that they did not complete the screening at the entrance, but upon reporting to the Orchard Hill Unit to begin the work shift. CNA C reported they completed the screening at the station located on the unit by taking her temperature and answering the questions on the form, then returning the form to the green folder, and donning a mask. CNA C pointed to the high counter in the kitchen area previously observed by this Surveyor. When asked what they would do if they determined they had a fever upon taking her temperature and completing the screening form, CNA C reported they would take the form to the nursing office on the unit for review. When asked where the nursing office was located, CNA C pointed to a closed door approximately one-third of the way down the hallway toward the resident rooms. An observation on 4/17/20 at 12:20 p.m. in the Lakeshore Cottage unit revealed a similar layout as the Orchard Hill Unit. The high counter separating the kitchen serving area and the hallway held a small container of hand sanitizer, a thermometer and a green file folder containing unused Employee - Coronavirus Screening Forms. To access the screening tools, staff would be required to walk between the resident living and dining areas. There were five residents sitting at separate tables in the dining area at the time of the observation. One resident was seated at the low counter between the dining area and the kitchen serving area, within approximately five feet of the employee screening station. An interview with CNA E, on 4/17/20 at 12:25 p.m., in the Lakeshore Cottage Unit, revealed staff were instructed to screen for Covid-19 symptoms upon arriving on the unit they were assigned to work. When asked at what point upon arrival did they don a mask after arriving to work, CNA E replied they put on a mask after completing the COVID-19 screening on the unit. When asked if they walked through the building and into the care area before screening and donning a mask, CNA E reported, Yes, and stated they completed the screening by taking their temperature, recorded the reading on the screening form, answered the screening questions and donned a mask, all after entering the residential unit. An interview with Registered Nurse (RN) A, on 4/17/20 at 12:40 p.m., revealed staff had a choice of where to complete the employee screening for COVID-19. RN A stated the facility had employee screening stations located at the entrance to the building, the unit clerk's desk in the lobby and on each unit. When asked where the screening forms were placed after completion, RN A reported staff should deliver their screening forms to the nursing office on their respective units. An observation of the Antrim Lodge Unit, on 4/17/20 at 12:50 p.m., revealed the same layout and location of the employee COVID-19 screening tools as on the Orchard Hill and Lakeshore Cottage Units. There were three residents present in the dining area at the time of the observation. One resident was seated at the counter within close proximity to the employee screening station. An observation of the Cedar River Unit, on 4/17/20 at 1:30 p.m., revealed a COVID-19 employee screening station inside the entrance to the unit. An Interview with RN O at the time of the observation, revealed their understanding of the employee screening process was for clinical staff to screen themselves for infection on their assigned units, not at the screening station located at the designated employee entrance to the facility. RN O reported upon arriving for work, staff on the Cedar River Unit take their own temperatures, fill out the screening form and deliver the completed form to the nursing office on the unit. RN O reported housekeeping and dietary staff did not screen on the units but at the screening station located at the designated employee entrance. When asked how they knew that everyone on the unit had completed a screening prior to working, RN O replied, I just assume everyone is sticking to the policy. Further observation of the Grass Creek Unit, revealed to reach the unit's nursing office from the screening station, required travel through a portion of the unit's living area. One resident was present in the living area at the time of the observation. An interview with the Director of Nursing (DON), on 4/17/20 at 2:40 p.m., revealed clinical staff had been instructed to screen at the stations provided on their prospective units to help decrease the bottleneck at the employee entrance. When asked to clarify, the DON verified the process that clinical staff entered the building and traveled, unmasked, to the units on which residents resided, to complete the screening for COVID-19 symptoms and exposure. When asked about the disposition of the forms after completion by staff, the DON reported staff place the completed forms in the green folders located at each screening station and the forms are picked up by the unit clerk, sometime in the morning, and taken to the Human Resources Department. An interview with Staff N, on 4/17/20 at 3:28 p.m., revealed they worked at the front desk as a unit clerk. Staff N reported after morning shifts had begun, they picked up the completed, Employee - Coronavirus Screening Form(s) from the green folders at the screening stations, which included the designated employee entrance, the desk in the front lobby, and from each clinical unit. Staff N reported they then delivered the completed forms to the Administrative Assistant to be filed. During an interview with the Nursing Home Administrator (NHA) and the DON, on 4/17/20 at 3:40 p.m., the DON was asked if any employee screenings had resulted in having a staff member leave work due to risk of possible COVID-19 infection. The DON replied they had sent an employee home on 3/25/20 due to a positive screening. The screening document used to determine the positive screening for the employee was requested at that time. The DON was asked if there was concern that a staff screening may show symptoms of, or exposure to COVID-19 during the required screening, with the staff person entering the resident care unit, unmasked, to complete the screening. The DON stated they understood the concern. A review of the, Employee - Coronavirus Screen Form, dated 3/25/20, provided by the DON, revealed the staff member (will remain confidential to protect personal health information) had a low-grade fever, cough and sore throat. A telephone interview with the confidential staff member, on 4/21/20 at 9:11 a.m., revealed they had entered the building without at mask, travelled from the designated employee entrance to the lobby, screened themselves by taking their temperature and completing the screening form. The staff member reported upon completing the screening, they donned their mask and proceeded to report to their workstation, and awaited the arrival of the DON to discuss the results of their

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235025	A. BUILDING _____ B. WING _____	**04/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEADOW BROOK MEDICAL CARE FACILITY	**4543 SOUTH M-88 HIGHWAY BELLAIRE, MI 49615**

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	(continued... from page 1) screening. Upon the DON's arrival, the staff member reported they took the screening form to the DON for review and were subsequently sent home due to symptoms of COVID-19 and instructed to seek guidance from their personal physician. The staff member was quarantined for 14 days after the positive screening was reported to the DON. An interview with the NHA on 4/21/20 at 11:08 a.m., revealed the process of having clinical staff travel through the building to screen in the resident care area was for staff to have access to nursing if screening indicated signs of, or exposure to, COVID-19. A review of the Centers for Disease Control (CDC), Infection Control Guidance, updated 4/13/20, revealed the following, in part: To address asymptomatic and pre-symptomatic transmission, implement source control (masks) for everyone entering the healthcare facility . Actively screen everyone for fever and symptoms of COVID-19 before they enter the healthcare facility.