STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235432	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRAYLING NURSING & REHAB COMMUNITY	**331 MEADOWS DRIVE GRAYLING, MI 49738**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow Center for Disease Control (CDC) guidelines during a focused COVID-19 Infection Control survey regarding isolating new admissions for 14 days and failed to ensure infection control standards were maintained regarding the COVID-19 Unit where two Residents (#1 and #2) who had tested positive were residing. This deficient practice resulted in the potential for spread of COVID-19 to the entire facility population of 44 Residents . Findings include: On 8/5/20 at 10:10 a.m., an interview was conducted with Registered Nurse (RN) C who reported she was also in charge of the Infection Control program. When asked where she was isolating new admissions, RN C reported they were isolated on one wing. On 8/5/20 at 10:28 a.m, RN C was observed in Resident #1's room wearing a white cloth lab coat. RN C was explaining to Resident #1 that he had to be isolated on precautions for 14 days because he had been out of the building to an appointment. RN C then exited the room with the lab coat gown on and continued down the hall. On 8/5/20 at 10:30 a.m., RN C came back to report that she had misspoken regarding the isolation of new admissions. RN C stated, We have them tested before they come in, and they are negative. So we know they don't have COVID. So we don't put them in isolation. When asked to clarify that the facility was not isolating new admissions for 14 days on contact and droplet precautions, RN C stated, Correct. On 8/5/20 at 10:36 a.m., Certified Nurse Aide (CNA) B was observed at the nursing station. She was wearing an N95 respirator, a face shield, and a gown. CNA B was then observed to go into the COVID-19 isolation unit. Approximately 1 minute later, CNA B was heard coming through the door where she dropped her pen onto the floor and it rolled from under the door of the COVID-19 side to the main hub of the building connecting to the nurses station. CNA B then exited the COVID-19 isolation unit, picked up her pen from the floor, and proceeded to continue to the nurses station where she began speaking with other staff. On 8/5/20 at 10:40 a.m., when asked whether she had just entered and exited the COVID-19 unit, CNA B stated, Yeah. When asked if she had doffed (removed) her PPE, CNA B stated, No. I was going to but I had to talk to someone (out here) so I didn't get a chance. When asked if she normally went on and off the COVID-19 unit and then back into the general resident population, CNA B stated, Yes, sometimes. I am going to go there for lunch to cover (for another CNA). A review of Resident #1's record revealed she admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #1 was observed residing on the COVID-19 isolation unit. Prior to being moved to the COVID-19 unit, Resident #1 had lived two doors down on the opposite side of the hall as Resident #2. A review of Resident #2's record revealed she admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was tested for COVID-19 on 8/2/20 and her test result came back Positive on 8/2/20, per the facility COVID-19 Log. Review of the COVID-19 positive log, the neighbor who shared the bathroom of Resident #1 tested positive for COVID-19 on 7/28/20. On 8/5/20 at 10:40 a.m., RN A was observed entering the COVID-19 unit. She was observed to doff her gown and sanitize her faceshield. When asked what she was doing on the COVID-19 unit, she reported that she was covering for the unit nurse's lunch. When asked if she intended to go back on to the other units with non-COVID-19 residents, RN A stated. Yes. But I change my gown. When asked if there was a separate exit and entrance for the COVID-19 unit so that staff working on the unit did not have to go back through the facility and potentially cross-contaminate, RN A stated, No. A review of the facility policy titled 2019 Coronavirus (COVID-19) dated 7/2020 revealed, .(pg 3) .Identify space in the facility that could be dedicated to care for residents with confirmed COVID-19. This could be a dedicated flour, unit, or wing . Identify HCP (health care professionals) who will be assigned to work only on the COVID-19 care unit when it is in use .(pg 10) Admissions. Nursing homes should admit any individuals that they would normally admit to the facility .All residents admitting 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 that has like [DIAGNOSES REDACTED]. All recommended PPE (Personal Protective Equipment) should be worn during care of residents under observation . A review of the CDC document published 7/25/20 titled, Preparing for COVID-19 in Nursing Homes revealed, .Identify space in the facility that could be dedicated to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19 . Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19 .Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission .If extended use of gowns is implemented as part of crisis strategies, the same gown should not be worn when caring for different residents unless it is for the care of residents with confirmed COVID-19 who are cohorted in the same area of the facility and these residents are not known to have any co-infections . On 8/6/20 at 10:35 a.m., a phone interview was conducted with the Administrator, Director of Nursing (DON), and RN C. When asked whether RN C should have doffed the white lab coat for a new one when she exited the isolation room for Resident #1, the Administrator stated, Probably. When asked why the facility was not isolating new admission for 14 days the Administrator stated, We are. We changed things up this morning. When asked if they had been isolating them as of 8/5/2020, the Administrator stated, No. When asked about the lack of consistent staffing and a separate entrance and exit for the COVID-19 isolation unit, the Administrator stated, We do the best we can with the staff available. We try to keep the same person (staff) on that unit the whole day when we can. We don't have the staff or the resources (for a separate unit). And we follow CDC guidelines and have them change into another gown. The Administrator was told CNA B was observed and interviewed about going on and off the COVID-19 unit without changing her gown or sanitizing. When asked if CNA B was commonly providing care for COVID-19 Residents and then providing care for non-COVID-19 Residents, the Administrator stated, Yes. When asked if the facility had identified the correlation between the cluster or Residents in rooms [ROOM NUMBER] being on the unit with new admissions that had not been isolated, the Administrator stated, We didn't have a new admission section. When asked if the new admissions had been spread throughout the building, the Administrator stated, Yes. When asked if they had been isolated from the rest of the Residents, the Administrator reported that they had started to do isolation as of 8/6/20.

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.