STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235371	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF YALE, INC	90 JEAN ST YALE, MI 48097

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F 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to operationalize policies and procedures to promote and ensure dignity for one (#5) of one Residents reviewed for dignified care resulting in a severely cognitively impaired Resident being exposed and visible from the hallway of the facility. Findings include: On 9/15/20 at 9:56 AM, Resident #5 was observed in bed, positioned on their back from the hallway of the facility. The Resident was yelling out and uncovered with their brief and bare legs visible from the hallway. Licensed Practical Nurse (LPN) Q was observed standing at the medication cart in the hall, near the Resident's room at this time. Upon entering the room, Resident #5's call light was noted to be clipped to the side of their bed, hanging downward towards the floor, and not within their reach. A blanket was not in place near the Resident on the bed. An interview was attempted to be completed at this time. When asked a question, Resident #5 did not provide a meaningful response to the question asked but stated, There are needles in my legs. Resident #5 asked for assistance to adjust the pressure reduction boots in place indicating they were having pain. When asked additional questions, Resident #5 did not respond and continued to verbalize complaints of pain and needles in their legs. At this time, LPN Q was observed standing at the medication cart in the hallway and their assistance was requested for Resident #5. LPN Q entered the Resident's room and adjusted the pressure reduction boots in place on the Resident's legs. LPN Q left the Resident exposed when they exited the room. When asked why they left Resident #5 exposed and visible from the hallway, LPN Q did not a response. Record review revealed Resident #5's was most recently admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired, experienced delusions, and required limited to extensive assistance to perform Activities of Daily Living (ADLs). Review of Resident #5's care plans revealed a care plan entitled, The resident needs activities of daily living assistance . (Initiated and Revised: 3/18/20). The care plan included the interventions: -Ambulation: Non-ambulatory (Initiated: 3/19/20) -Bed Mobility: 2 Assist (Initiated: 3/19/20; Revised: 7/27/20) -Toilet Use: bedpan--hoyer needed (Initiated: 3/19/20; Revised: 7/27/20) -Encourage the resident to use call bell to request assistance (Initiated: 3/18/20) An interview was conducted with the facility Director of Nursing (DON) on 9/17/20 at 12:10 PM. When queried regarding facility policy/procedure related to a Resident being exposed with their brief and bare legs visible from the hall of the facility, the DON revealed Residents should not be exposed. The DON was then told about the observation that occurred on 9/15/20 of Resident #5 including LPN Q entering and exiting the room without covering the Resident. When queried if that was appropriate per facility policy/procedure, the DON revealed they would fix it immediately if they would have saw the Resident. When asked what actions should have been taken, the DON stated, I would have asked (Resident #5) if they wanted a blanket. The DON further revealed that if the Resident did not want a blanket, the privacy curtain in the room could have been pulled to provide privacy. A policy/procedure related to Resident privacy/dignity was requested from the facility administrator on 9/16/20 at 10:24 AM but not recieved by the conclusion of the survey.
F 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure assessment and documentation of incompetency prior to enacting a Durable Power of Attorney (PDOA) for one (#42) of six Residents reviewed for Advance Directives, resulting in enactment of the DPOA with medical care decisions being made for the Resident with no legal documentation of determination of incompetency and the potential for the Resident's care wishes to not be followed. Findings include: Record review revealed Resident #42 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required extensive to total assistance to perform Activities of Daily Living (ADLs). Additional review of the Residents medical record revealed an individual other than the Resident had signed legal documentation including consent for [MEDICAL CONDITION] medications. Further review revealed the individual who had been signing legal documents for the Resident was listed as the Resident's DPOA on DPOA documentation within the medical record. The DPOA specified the DPOA became effective if the Resident was no longer able to make their own decisions. Resident #42's medical record also contained an incompetency document form signed by only one Physician. An interview was conducted with the Director of Nursing (DON) and the Social Services Director on 9/17/20 at 12:03 PM. When queried regarding Resident #42's competency and ability to make their own decisions, both the DON and Social Services Director indicated the Resident was not able to make their own decisions. When queried regarding documentation of incompetency for the Resident, both the DON and Social Services Director reviewed the medical record and provided the incompetency document only signed by one Physician. When queried how many Physicians are supposed to sign an incompetency documentation in order to determine that a Resident is unable to make their own decisions, the Social Services Director stated, Two. When asked why the DPOA was signing the Resident's legal documentation when only one Physician signed the incompetency document, both the Social Services Director and the DON revealed the incompetency document should have been signed by two Physicians and they were unsure how it had been missed. No further explanation was provided. A policy/procedure related to Advance Directives was requested from the facility Administrator on 9/16/20 at 10:24 AM but not received by the conclusion of the survey.
F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure placement and documentation of placement of a right-hand splint for one sampled resident (R48), resulting in the potential for worsening upper extremity impairment. Findings include: On 9/15/20 at 10:13 AM, R48 was observed to be receiving AM care from two Certified Nursing Assistants (CNAs), CNA H and CNA I. The resident was transferred to a reclining chair. R48's right hand and wrist appeared to be weak and without good muscle tone and was slightly flexed. No supportive device was noted on the right arm. On 9/15/20 at 1:28 PM, Confidential Witness J was interviewed via phone regarding R48's care at the facility. When queried regarding a

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) supportive device for the resident's right hand, Witness J stated, (R48) is supposed to wear one on the right arm. On 9/15/20 at 1:45 PM, R48 was observed sleeping in bed. No supportive device was noted on the resident's right arm. A splint device was noted to be sitting on the resident's dresser toward the end of their bed. On 9/16/20 at 10:24 AM, R48 was observed sitting up in their chair. The splint device was noted to be sitting on the resident's dresser and not on the resident's right arm. On 9/16/20 at 12:11 PM and 12:29 PM, R48 was observed sitting up in bed eating lunch. The splint device was noted to be sitting on the resident's dresser and not on the resident's right arm. On 9/16/20 at 2:30 PM, 3:40 PM, and 4:23 PM, R48 was observed sleeping in bed. No supportive device was noted on the resident's right arm. The splint device was noted to be sitting on the resident's dresser. On 9/17/20 at 9:17 AM, R48 was observed sitting up in their chair. The splint device was noted to be sitting on the resident's dresser and not on the resident's right arm. A review of R48's care plan revealed the following: Splint to Right hand on 4-5 hours a day-check skin before applying and when removing-if any skin concerns develop, leave off and notify nurse immediately Date Initiated: 01/03/2020 Revision on: 04/20/2020. On 9/17/20 at 10:55 AM, the Nursing Home Administrator (NHA) was asked for a policy/procedure related to splint/brace application. The NHA stated, We do not have a specific (policy) for the splints/braces and application, we follow the physician's orders [REDACTED]. On 9/17/20 at 11:50 AM, R48 was observed sitting up in their recliner. The splint device was noted to still be sitting on the resident's dresser and not on the resident's right arm. CNA H entered the room and was queried regarding the application of the device and documentation of application, CNA H stated, Therapy was putting the splint on .When we put it on, (R48) doesn't like it. We haven't been putting it on (R48). When queried where refusal of splint application was documented, CNA H stated, We don't have a spot to document it on our charting. R48's medical record and progress notes were reviewed and found no documented refusals of splint application. On 9/17/20 at 12:03 PM, the Therapy Manager was queried regarding the splint for R48's right arm. The Therapy Manager stated she would look through her notes and it had been a while since the resident received therapy. The Therapy Manager was queried who was responsible for implementing brace application if therapy is no longer working with the resident and replied, It would be up to nursing to implement. On 9/17/20 at 12:14 PM, the Therapy Manager approached and stated, Back in December 2019 we educated staff on donning and doffing the brace (for R48), the wearing schedule, and then our process is that I put in a recommendation for a care plan update and give that to nursing staff. Up to nursing staff to implement. A review of R48's Occupational Therapy Treatment Encounter Note(s), dated 12/9/19 revealed: Discharge Recommendations: Restorative Splint and Brace Program .RUE (right upper extremity) splint 4 hours per day . Note on the same document dated 12/6/19 revealed, .Educated restorative CENA (CNA) on new splint . Note dated 12/4/19 revealed, .Resident tolerated 4 hours of right hand splint wear. Hourly checks completed and no signs of [MEDICAL CONDITION] or redness. CENA's educated on checking for any signs of irritation .Staff educated on splint wear .compliant with skilled interventions. On 9/17/20 at 2:44 PM, the Director of Nursing (DON) was interviewed regarding R48's right-hand splint. When queried if splint application was documented in the resident's record, the DON indicated she did not see any documentation. When asked if there should be documentation of splint application, the DON stated, It should be documented somewhere, yes. When asked if it was her expectation for staff to document any resident refusals of splint application, the DON stated, Yes. The DON reviewed R48's care plan and indicated the splint application was not on the Kardex (quick care reference for staff) and stated, That's odd. I just added it to the Kardex. A review of R48's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was admitted into the facility on [DATE] and re-admitted on [DATE] with medical [DIAGNOSES REDACTED]. Further review revealed the resident was cognitively impaired and required extensive assistance from one or more staff for bed mobility, transfers, dressing, toilet use, and hygiene. A review of the facility's policy/procedure titled, Restorative Nursing Program, dated 3/2019, revealed, The Restorative Nursing Program is led by the Director of Nursing (DON) or designee (i.e. Restorative Nurse, Unit Manager, Nurse Manager). The program is multidisciplinary and includes: Therapy (PT, OT, ST), Nursing (RN, LPN, RNA, CENA) .Resident .Employees that have been trained and shown competency may complete and participate in group restorative activities. Once determined that the resident would benefit from a restorative nursing program, implement the following: Determine if the resident is willing and able to participate, Document refusal in the medical record with education regarding risks and benefits. Re-visit at least quarterly to determine if the resident would still benefit. Determine willingness and ability and document refusals as previously completed, Determine resident and/or family goals for restorative care, Review during care plan review meeting .
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to operationalize policies and procedures to ensure consent is obtained for [MEDICAL CONDITION] medication administration for one (#5) of five Residents reviewed for [MEDICAL CONDITION] medications resulting in lack of consent for [MEDICATION NAME] (atypical antipsychotic medication used cautiously in elderly individuals) administration. Findings include: Review of Resident #5's medical record revealed the Resident was most recently admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired, experienced delusions, and required limited to extensive assistance to perform Activities of Daily Living (ADL). Review of Resident #5's Medication Administration Record [REDACTED]#5's medication order history revealed the Resident had taken [MEDICATION NAME] in March 2020, but it had been discontinued. [MEDICATION NAME] was ordered again due to behaviors and the Resident began taking the medication in June 2020. From June 2020 to September 2020, the medication dosage had been adjusted. Review of medication consents in Resident #5's medical record revealed a signed consent dated 3/20/20 for both [MEDICATION NAME] (no dose) and [MEDICATION NAME] (no dose) for generalized anxiety. An interview was conducted with the Social Services Director on 9/17/20 at 8:53 AM. When queried if [MEDICAL CONDITION] medication consent forms had to have the medication dosage, per facility policy/procedure, the Social Services Director stated, I've never been told to. It (dose) would be in the notes. When asked how Residents and/or Resident Representatives are informed of changes in medication dosages, the Social Services Director replied, (Provider) contacts the POA (Power of Attorney) if (Resident) not own responsible party. When asked if a different consent form is supposed to be utilized for each medication, the Social Services Director stated, No, we can use the same form for each med. A review of Resident #5's [MEDICATION NAME] medication therapy was completed with the Social Services Director at this time. When queried regarding a consent for the medication, the Social Services Director reviewed the Resident's medical record and revealed the only consent present in the medical record was from March, prior to the medication being discontinued. When asked if a new consent is required after a medication is discontinued and then restarted several months later, the Social Services Director indicated a consent should have been obtained and stated, I can't believe I missed that. The Social Services Director further indicated a consent would be obtained today. On 9/17/20 at 12:46 PM, an interview was conducted with the Director of Nursing (DON). When queried regarding lack of consent for [MEDICAL CONDITION] medication administration for Resident #5, the DON indicated a consent should be obtained whenever a [MEDICAL CONDITION] medication is ordered. No further explanation was provided. A policy/procedure pertaining to [MEDICAL CONDITION] medications including consents was requested from the facility Administrator on 9/16/20 at 10:30 AM but not received by the conclusion of the survey.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the disposal of expired medications and failed to label and store medications appropriately on the B, E, and F units, resulting in the potential for resident's to

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) receive ineffective medications. Findings include: On 09/16/2020 at 10:15 AM, the B-Wing medication cart was reviewed for medication storage with Registered Nurse (RN) A. Upon inspection of the medication cart, an opened bottle of Aspirin 81 milligrams was observed with the manufacture's expiration date of 7/20 in the top drawer of the medication cart. RN A explained that the nurse on the previous shift was supposed to look through the cart and throw away any expired medications and must have missed it. A tour of the F-Unit Medication Cart was completed on 9/16/20 at 8:08 AM with Licensed Practical Nurse (LPN) P. The following expired, undated, and/or un-labeled medications were noted in the cart: -One bottle of Cranberry 405 milligram (mg) capsules, quantity 60. Expired 04/20 -One bottle of Stool Softener Docucate Sodium 100 mg softgels, quantity 100. Expired 08/20 -One six fluid ounce (oz) bottle of Sore throat spray, cherry flavor ([MEDICATION NAME] generic). The bottle was opened, undated, and not labeled with Resident name/identification -[MEDICATION NAME] (insulin) 100 units/milliliter (mL) pen for Resident #5, dated as Opened 7/26. The sticker label on the insulin revealed, Good for 28 days after opened -Latanoprost 0.005% eye drops for Resident #52, opened and not dated -Latanoprost 0.005% eye drops for Resident #52, unopened and not refrigerated. The medication was delivered 9/1/20 and clearly labeled, refrigerate until opened. When queried regarding the Latanoprost 0.005% eye drops being unopened and in the medication cart, LPN P stated, Should have been refrigerated. When queried regarding the insulin being past 28 days in which it is able to be used and the expired/unlabeled medications in the cart, LPN P indicated they would dispose of the medications. No further explanation was provided. A tour of the E-Unit medication cart was completed with LPN C on 9/16/20 at 11:29 AM. A 100 count bottle of Aspirin 325 mg tablets was present in the cart. The Aspirin expired 08/20 and was dated as opened on 8/31/20. When asked, LPN C revealed the medication was floor stock and used for any Resident on the floor who has it ordered. When queried regarding the medication being opened on the date it expired, LPN C was unable to provide further explanation. An interview was completed with the Director of Nursing (DON) on 9/17/20 at 12:46 PM. When queried regarding facility policy/procedure pertaining to disposal of expired medications, labeling of medications, and temperature storage per manufacturer recommendations, the DON revealed they were aware of the concern. The DON further indicated they would address the issue. No further explanation was provided. A record review of the facility policy titled, Storage of Medications revised 6/23/16 revealed the following: 2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner . 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed .
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 operationalize policies and procedures to implement a comprehensive infection control program including assessment and application of infection control and isolation procedures per Centers for Disease Control (CDC) recommendations and standards of practice for newly admitted Residents and Residents with new onset respiratory infection symptoms and failed to implement comprehensive surveillance and tracking of signs/symptoms of infections for five sampled (#'s 18, 34, 57, 60, and 187) and one unsampled Resident of two Residents reviewed for respiratory infections resulting in lack of readily accessible hand hygiene equipment, inadequate utilization of Personal Protection Equipment (PPE), lack of dedicated equipment for Residents in the isolation unit, and the likelihood for spread of infection to all Residents within the facility. Findings include: An interview was conducted with the facility Administrator on 9/15/20 at 9:15 AM. When queried regarding facility policy/procedure pertaining to Residents admitted /re-admission related to current Covid-19 recommendations, the Administrator revealed Residents who are admitted or readmitted to the facility are placed in designation isolation unit (E Hall) for 14 days. When asked what PPE is utilized, the Administrator indicated gowns, gloves, an N-95 (respirator mask that is worn snuggly to the face to filter 95% of 0.3 microns sized airborne particles) covered by a blue droplet mask, and eye protection (face shield or goggles). The Administrator further specified that PPE is donned (applied) before entering each Resident room and doffed (removed) before exiting the room. When asked, the Administrator detailed that facility Staff change the blue mask covering their N95 mask between each Resident and must clean googles/face shield prior to exiting the Resident's room. On 9/15/20 at 9:09 AM, Resident #18 was observed in their room in bed. An interview was conducted at this time. When asked how they were feeling, Resident #19 revealed they were still having a rash. With further discussion, the Resident was confused and unable to provide meaningful responses when asked direct questions. A tour of the new admission isolation unit (E hall) of the facility began on 9/15/20 at 10:18 AM. The isolation unit was separated from the other hall of the facility by a moveable wall petition that was open on the top and bottom. Upon entering the unit, all the doors of occupied Resident rooms were noted to be open. Coughing from within several Resident rooms could be heard from the hallway and no staff were present in the hallway. A wrist style blood pressure monitor and an oral thermometer where noted sitting on the nurses' medication cart and on a table in the hall. Each Resident room door had a hanging PPE station in place on the room door. Two hand sanitizer dispensers were present on the walls in the isolation unit, both dispensers were located near the movable petition wall. On 9/15/20 at 10:23 AM, Unsampled Resident A was observed in their room in bed and a hanging PPE station was noted on the outside of their open room door. After donning PPE and entering the room, an interview was completed. When asked what PPE staff wear when they enter their room to provide care, Unsampled Resident A replied, Don't always wear it. At this time, Unsampled Resident A began coughing. Their cough was moist and harsh sounding. When asked, Unsampled Resident A revealed they had been coughing for a couple days but was unable to recall the specific date when the cough started. When asked if they had been tested for Covid-19 infection, Unsampled Resident A indicated they had not been tested recently. Unsampled Resident A was then asked what equipment staff use to monitor their vital signs, including temperature, and replied, They (staff) bring it (vital sign monitoring equipment) in. When asked, Unsampled Resident A revealed the door to their room is always left open. No dedicated vital sign monitoring equipment was observed in the Resident's room. A container of cleaning wipes was noted in the Resident's bathroom. After doffing PPE to exit the Resident's room, hand hygiene equipment was not readily accessible. A hand sanitizer dispenser was not present in the Residents room and it was necessary to walk back into the room, without PPE and within six feet of the Resident, to utilize the sink in the Resident's room which the Resident also uses. At 10:36 AM on 9/15/20, Resident #187 was observed in their room in the isolation unit of the facility and an interview was completed. When asked, Resident #187 revealed they had recently returned to the facility from the hospital. When asked the reason they were in the hospital, Resident #187 stated, Infections. When asked, Resident #187 revealed they were coughing occasionally. When queried if staff wore PPE when they entered their room, Resident #187 revealed staff do not consistently wear PPE. Observation of Resident #187's room and storage areas within their room revealed there was no dedicated vital sign monitoring equipment present. A container of cleaning wipes was noted in the Resident's bathroom. When asked how staff monitor their temperature and other vital signs, Resident #187 replied, They (staff) bring in a thermometer, wrist blood pressure, and finger thing (portable oxygen saturation monitor). Record review revealed Resident #187 was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required extensive to total assistance to perform Activities of Daily Living, except for eating. Review of Resident #187's laboratory diagnostic testing results in the medical record revealed the Resident was most recently tested in the facility for Covid-19 infection on 8/19/20. On 9/15/20 at 10:46 AM, an observation of Resident #57 and their roommate occurred in the isolation unit of facility. A hanging isolation PPE cart was present on the open door of the room. Resident #57's roommate was sitting in a reclining chair with their eyes closed, directly next to the open door of the room. The Resident was within two feet proximately of the open door and hallway. In order to don PPE, with the room door open, physical distancing of six feet was unable to be maintained. Resident #57 was observed sitting in a chair next to their bed and an interview was conducted. When asked how they were feeling and if they had any signs and/or symptoms of Covid-19, Resident #57 revealed they had a cough. A container of cleaning wipes was noted in the Resident's bathroom and dedicated vital sign monitoring equipment was not noted in the room. Record review revealed Resident #57 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required extensive assistance to perform Activities of Daily Living (ADLs). On 9/15/20 at 11:48 AM, an interview was conducted with Physician Assistant L and LPN C in the hallway of the facility isolation unit. When queried regarding facility policy/procedure pertaining to Covid-19 screening and Resident admissions/re-admissions, Physician Assistant L stated, They (Residents) have to have a negative test from the hospital. When asked if Residents are admitted if they do not have a negative Covid-19 test, Physician Assistant L replied, I don't

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The Resident was focused on having a rash when speaking to them and did not provide responses to questions when asked. An interview was completed with Nursing Assistant F on 9/16/20 at 8:03 AM. When queried regarding Resident #18, Nursing Assistant F replied, (Resident #18's) real problem is the rash thing. It's like scabs. At 8:05 AM on 9/16/20, an interview was conducted with LPN K. When queried regarding Resident #18, LPN K stated, (Resident #18) just went to dermatology (appointment). When asked the date of Resident #18's appointment, LPN K replied, I am not sure what the date was, but I know the nurse got a call about the biopsy report. When asked if a Dermatology provider came to the facility or if Resident #18 left the facility to go to the appointment, LPN K stated, (Resident #18) went out to the appointment. When asked, LPN K indicated the Resident went to the appointment within the past two weeks. With further inquiry, LPN K revealed they would find the date the Resident went to the dermatologist and would follow up as the note was not scanned into the Electronic Medical Record (EMR). LPN K was then asked if Resident #18 was placed in isolation precautions after leaving the facility to go to the external dermatology appointment and replied, No. Record review of Resident #18's medical record revealed the Resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required limited to extensive assistance to perform Activities of Daily Living (ADLs). Additional review of Resident #18's medical record revealed Resident #18 had been in their current room in the facility since 11/4/19. On 9/16/20 at 11:41 AM, an oral thermometer and a wrist blood pressure measurement device were observed on the medication cart in the isolation unit of the facility. An interview was conducted with Licensed Practical Nurse (LPN) C at this time. When queried regarding facility policy/procedure for obtaining vital signs, LPN C replied, Nurses and CNAs (Nursing Assistants) do vital signs. LPN C was then asked the frequency in which blood pressure is measured and replied, Midnights do every day. I only do them if I need it for meds (medication administration). When asked what equipment is utilized to obtain Resident vital sign measurements, LPN C indicated there should be dedicated equipment in each Resident's room. When queried why there was a thermometer and a wrist blood pressure monitoring device on the top of the medication cart, if there is dedicated equipment in each Resident room, LPN C revealed staff also use the vital sign monitoring devices on the medication cart. When queried how frequently Resident temperatures are taken, LPN C replied, Every shift. LPN C was then asked what device is utilized by staff to obtain Resident temperature and stated, We have a no contact thermometer in the med cart. At 11:54 AM on 9/16/20, Nursing Assistant G was pushing Resident #57 out of the shower room of the facility and down the hallway of the isolation unit in a wheelchair to the Resident's room. The shower room was located at the opposite end of the hall from the Resident's room. Nursing Assistant G did not have on gloves or a gown and the only PPE in place was a KN-95 mask without a droplet/procedural mask over the KN-95 mask. Resident #57 was wearing a hospital gown and had a droplet/procedural mask over their mouth. Upon reaching the Resident's room, Nursing Assistant G proceeded to enter the open doorway of the room while pushing the Resident in the wheelchair. After the Resident was just past the open door of the room (approximately three feet), Nursing Assistant G began donning PPE located in the hanging PPE cart on the door of the room. Nursing Assistant G did not perform hand hygiene prior to beginning to don PPE. An interview was conducted with Nursing Assistant G at this time. When queried, Nursing Assistant G revealed Resident #57 requires assistance with ADL care and that they had just provided a shower to the Resident. Nursing Assistant G was then asked what PPE was worn when assisting the Resident to shower and replied, Just a mask and pointed at the KN-95 mask they were currently wearing. When asked if they have to wear a gown or other PPE, per facility policy/procedure, due to the Resident currently being on isolation precautions related to admission and Covid-19, Nursing Assistant G stated, The Resident wears a blue (droplet/procedural) mask so we don't have to wear anything else. When queried if gloves were worn while showering the Resident, Nursing Assistant G replied, Well yeah. Nursing Assistant G was then asked if the wheelchair used to transport the Resident remained in their room and they indicated it did. With further inquiry regarding touching the Resident's wheelchair when pushing them in the hall without gloves, Nursing Assistant G indicated they did not think about touching the wheelchair. Nursing Assistant G was then asked about donning PPE without performing hand hygiene and revealed hand sanitizer and/or a sink were nearby to utilize. When queried regarding facility policy/procedure related to obtained Resident's vital signs on the isolation unit of the facility, Nursing Assistant G revealed both nursing and nursing assistants obtain Resident vital sign measurements. Nursing Assistant G stated, We do and sometimes nurses. We do on shower days. Nursing Assistant G was then asked what monitoring equipment is utilized to obtain vitals signs for Residents on the isolation unit and replied, They (Residents) should have vital sign equipment in their room. When asked if Resident #57 had vital sign monitoring equipment in their room, Nursing Assistant G entered the Resident's room, looked in various places, and stated, No, not in here. When queried if Resident #57's roommate had dedicated vital sign equipment in their room, Nursing Assistant G looked in the room and revealed there was also no dedicated vital sign equipment for Resident #57's roommate in the room. At 12:00 PM on 9/16/20, LPN C was observed exiting a Resident room on the isolation unit of the facility carrying a glucometer (medical device utilized to obtain Point of Care (POC) blood glucose levels). LPN C placed the glucometer directly on the top of the medication cart while unlocking the cart and then into a drawer in the medication cart without cleaning the device. An interview was completed at this time. When queried regarding disinfection and cleaning of the glucometer after using for a Resident on isolation precautions, LPN C stated, I used the peroxide wipes in the Resident's bathroom. LPN C was then asked if they had walked back through the Resident's room past the Resident without PPE and with the uncovered glucometer after cleaning it with a peroxide wipe in the Resident's bathroom and replied, Well, yes. When queried regarding facility policy/procedure pertaining to storing cleaning wipes in Resident bathrooms and cleaning reusable medical equipment in isolation rooms where PPE is supposed to be worn, LPN C did not provide further explanation. A review of the facilities Infection Control (IC) program was scheduled to be completed on 9/16/20 at 1:30 PM and transpired at 1:34 PM with the facility IC LPN D, Unit Manager Registered Nurse (RN) E and the Director of Nursing (DON). When asked to review facility IC surveillance and tracking including Covid-19 infections, IC LPN D stated, We don't have no Covid. When asked if they had ever had any Residents with Covid-19, IC LPN D replied, We put them on isolation on E-wing. When queried regarding facility staff, including contracted staff who had tested positive for Covid, IC LPN D revealed a therapy staff had recently tested positive. Facility staff were then queried regarding surveillance and tracking of Residents with signs/symptoms of Covid-19 and indicated all newly admitted Residents are placed in isolation to monitor Covid-19. When queried regarding testing for Covid-19, the DON stated, Staff are being tested weekly. When asked if Residents were also tested weekly, the DON replied, No, not unless they have something on their Covid screen. The DON was then queried regarding the facility policy/procedure pertaining to new admissions and replied, They (new admits) to unit on isolation. We do a Covid test if they have not had a test within 72 hours (of admission). When asked about facility policy/procedure if a Resident did have a test within 72 hours of admission, the DON stated, If they have had a test, then we do not. When asked if the facility is using the testing or symptom method to monitor for Covid-19 infection, the DON stated, A combo really. Symptom method, we will decide on testing based on the symptoms. The staff were then queried regarding facility policy/protocol for new onset respiratory symptoms. IC LPN D stated, If it is Covid related then we test but it is individualized. With further inquiry, IC LPN D expanded, If there is a positive Covid screen then we talk to the Doctor. With further inquiry regarding the Covid screen completed for Residents in the Medication Administration Record [REDACTED]. When queried how comprehensive screening for signs and symptoms of Covid-19 is completed by facility nursing staff when they are not on the isolation unit consistently throughout their shift due to having a Resident assignment in a different hall (no dedicated staff for isolation unit) and Residents with decreased cognitive and physical function on the isolation unit, the DON replied, Well, this is not an acute care. With further inquiry related to not having dedicated staff assigned to the isolation unit, the DON stated, We base our nurses and nurses' aides (staffing) on acuity. The DON was queried regarding the Centers for Disease Control (CDC) recommendations pertaining to staff on an isolation unit and replied, The CDC does recommend dedicated staff. When questioned if all Residents who are admitted , readmitted , and/or leave the facility for an appointment are placed in isolation precautions in the dedicated isolation unit upon their return to the facility, IC LPN D replied, Yes. Facility staff were then asked about facility policy/procedure related to PPE use in the isolation unit. IC

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	235371	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF YALE, INC	90 JEAN ST YALE, MI 48097

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** - Many	(continued... from page 4) LPN D stated, PPE is changed for each room. When asked about staff face shields or goggles, IC LPN D stated, Wash in the room (with soap and water). When queried regarding PPE removal at the door of the room and staff having to reenter Resident rooms to utilize the sink to wash their face shield or goggles, IC LPN D did not provide an explanation. The DON then added, Or use a bleach wipe and indicated bleach wipes are maintained in the locked medication cart on the hall. When asked about the peroxide wipes observed in Resident bathrooms and observation of LPN C with the glucometer, both the DON and Unit Manager RN E replied, No and revealed cleaning wipes should not be kept in Resident bathrooms. The DON then stated, I can't believe it. That is not acceptable. Staff were then queried regarding the location of hand sanitizer in the unit including Resident rooms not having sanitizer dispensers and lack of easily accessible sanitizer in the hall of the facility. Unit Manager RN E indicated they were aware of the lack of readily available sanitizer and stated, I know they talked about it. When asked what PPE is required to be worn by staff when providing showering assistance to Residents on the isolation unit of the facility, Unit Manager RN E and IC LPN D both revealed all PPE (gloves, N95 mask, procedural/droplet mask), gown, and eye protection) should be worn. When asked what PPE staff should wear when taking a Resident back to their room after a shower in the hallway of the isolation unit, IC LPN D and RN E indicated gloves and a N95 mask with a droplet/procedural mask should be utilized. The DON stated, (Staff should) Wear all PPE in the shower and then in the hall. Remove when get back to room. When asked about vital sign monitoring equipment for Residents in isolation, all three staff revealed Residents on isolation precautions should have dedicated vital sign monitoring equipment in their room. When queried regarding observations of rooms not having dedicated equipment, RN E stated, I put one (vital sign equipment) in (Unsampled Resident A's) room yesterday. No further explanation was provided. When queried regarding all the Resident doors in the isolation unit being observed open and facility policy/procedure, the DON revealed the Resident room doors can be open per the Regional Nurse. With further inquiry regarding CDC recommendations regarding Resident room doors being open, the DON did not provide further explanation. Review of facility infection control surveillance and tracking data reviewed an undated and unsigned document for each month, except May 2020, related to process surveillance. Review of the document indicated process surveillance was completed once per month. The process surveillance form for June 2020 included a section, Transmission precautions are followed according to policy and procedures . The form included handwritten documentation of Nurse/CNA verbal education and further had a section PPE is used as required with See above written. When asked what occurred in June related to PPE, including location within the facility and if any infections resulted from improper PPE procedures, IC LPN D replied, I'm not sure. Review of line listing documentation revealed documentation of facility tracking of Residents who had received antibiotic therapy (medication treatment) for infections. When queried regarding tracking and documentation of Residents with infections prior to or who did not receive antibiotic treatment, IC LPN D revealed they do not track and monitor infection status of Residents who do not receive treatment. When asked how they are able to identify infections early and comprehensively when they are not actively tracking signs and symptoms of potential/actual infections, IC Nurse LPN D was unable to provide an explanation and/or documentation of surveillance. Further review of line listing documentation revealed Resident #60 was listed as having a respiratory infection with treatment in April 2020. When queried if Resident #60 had Covid testing, IC LPN D replied, Yes on 4/20 and reported on 4/24 (2020). When asked why the Resident was not tested for Covid until 4/20/20 when medical record documentation revealed the Resident had a temperature of 100.5 degrees Fahrenheit, coughing, sore throat, a decreased oxygen saturation of 93%, and shortness of breath when lying flat on 4/17/20, IC LPN D was unable to provide an explanation. When asked if the Resident was placed in isolation precautions and/or moved to a private room, IC LPN D revealed they were not sure and would have to look to determine if and when the Resident was moved/isolation was implemented. An interview was completed with the facility Administrator and RN N on 9/16/20 at 4:28 PM. When queried regarding facility policy/procedure regarding implementation of isolation precautions related to potential Covid-19 exposure for Residents, the Administration and RN N indicated newly admitted Residents are placed in the isolation unit of the facility for monitoring. When queried if Resident #18 had left the facility for an appointment outside, the Administrator indicated they had. When queried why the Resident was not placed in the Isolation unit upon their return to the facility, the Administrator revealed the Resident had worn a droplet/procedural mask when they left the facility. When queried if the Resident was in a private room and/or placed in isolation precautions upon their return to the facility, RN N reviewed the Resident's medical record and stated, No. A second interview was conducted with IC Nurse LPN D on 9/17/20 at 3:09 PM. When queried regarding the employee who had tested positive for Covid-19, IC LPN D revealed the employee was Speech Therapist M. When asked how the staff was identified as having Covid-19, IC LPN D revealed the employee tested positive but did not have symptoms. When queried regarding documentation of surveillance and tracking of employee call-ins and illness, IC LPN D revealed Therapy staff are contracted and the Therapy manager notified them of any staff call ins during their morning meetings. When asked where and how employee call ins are tracked in order to correlate trends of infection, IC LPN D revealed they get the call-in forms and presented a large pile of paper call in forms. When asked if the illness data from the call-ins was compiled for tracking and surveillance, IC LPN D stated, I like that and revealed they just reviewed the forms and remembered. With further inquiry regarding surveillance of the facility Residents treated by Speech Therapist M, IC LPN D revealed they did not have any surveillance/tracking data related to the Covid exposure. IC LPN D then revealed four Residents were placed on increased monitoring to every 4 hours. When asked how they knew what Residents to place on increased monitoring, IC LPN D stated, They (therapy) gave me a list. No further explanation was provided. On 9/15/20 at 10:42 AM, R34 was observed in their room. R34 was occupying the middle bed of three in the room and was observed to be forcefully coughing. When queried regarding the cough, the resident stated, I might have pneumonia. The resident did not have on a face mask, and both the resident's roommates did not have on face masks. On 9/15/20 at 1:55 PM, Licensed Practical Nurse (LPN) C was queried regarding R34's cough. LPN C stated, (R34) is awaiting a chest x-ray to rule out pneumonia. I wasn't here yesterday when the cough started. When queried if residents in the facility had been tested for COVID-19 recently, LPN C stated, They haven't been COVID tested in a while. R34 was heard and seen coughing in their room at this time. R34's roommates were still in the room and none of the residents were observed to have on face masks. On 9/16/20 at 10:16 AM, LPN K was queried regarding R34's chest x-ray that had been ordered. LPN K indicated the resident was still coughing and, has that back and forth. The x-ray was ordered on 9/14, done on 9/15, and LPN K pulled up the results on 9/16 which read Right middle lobe infiltrate. LPN K then stated the resident was on [MEDICATION NAME] (antibiotic) on 8/27 for pneumonia. Review of R34's progress notes revealed: 9/3/2020 13:23 SOC-Infection Type of infections/Signs & symptoms: Resident presented on 8-23-2020 with T (temperature) 102.3 (degrees Fahrenheit), confusion, cough, rhonchi, 02 sats of 88%. CXR (chest x-ray) ordered that showed modest right lobe infiltrates. 9/13/2020 05:14 Nurses' Notes Note Text: Add to note. O2 sat 91%. Respirations 18. Will continue to monitor. 9/13/2020 04:49 Nurses' Notes Note Text: Resident coughing still. Lungs sounds auscultated. Crackles heard in the right posterior, lower and upper lung. Will continue to monitor and place on doctor's log. Resident afebrile. 9/14/2020 08:33, Transcribed NP/PA Progress Note History Of Present Illness: This patient is being evaluated per nursing request due to crackles in lung bases with episodes of [MEDICAL CONDITION]. The patient currently is resting without O2 (oxygen) and pulse oximetry is greater than 90% .does have occasional cough but nonproductive per nursing .Will order a chest x-ray 2 views do the patient's crackles await results prior to changing any medications. The patient does not appear short of breath although did have episode of low SPO2 (blood oxygen level) .current SPO2 is greater than 90%. The patient is medically complex with multiple comorbidities and will require frequent monitoring, follow-up, and intervention for adequate symptom management. 9/15/2020 08:02, Transcribed physician progress notes [REDACTED]. Patient currently on room air sitting in wheelchair without respiratory distress. Patient is coughing frequently per roommates reports. Patient denies chest pain, fevers and no reported diarrhea. Patient past medical and social histories are reviewed .Will add additional [MEDICATION NAME] (water pill) 40 mg (milligrams) daily at 3 PM for 3 days. Await results of chest x-ray is given patient's diffuse crackles may be a component of fluid overload. Patient currently stable respiratory wise that (they are) off supplemental oxygen. Patient will require close followup to monitor results of chest x-ray. R34's progress notes did not mention COVID-19 and explanation of not testing the resident for COVID-19 was not mentioned in the documentation. On 9/17/20 at 9:08 AM, R34 was observed in the same room with two roommates present. The resident was standing up and getting ready to walk with therapy. R34 was observed to not have a mask on. A review of R34's vital signs revealed that the resident's SPO2 was 90.0% (ideally should be above 92%) on room air on 9/17/2020 at 10:29 AM. No SPO2 was recorded on 9/15 or 9/16. On 9/17/20 at 12:29 PM, the Infection Control Nurse (ICN) was queried regarding R34 and their respiratory symptoms. The ICN stated, The doctor looked at (R34's) history, that's why they did the chest x-ray. The resident has a history of pneumonia, that's how the history is, that's

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MEDILODGE OF YALE, INC	**90 JEAN ST YALE, MI 48097**

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 5) how (R34) gets. When queried regarding COVID-19 being known to cause pneumonia, the ICN stated, I understand COVID causes pneumonia. When asked if the facility was still performing weekly testing of residents for COVID-19, the ICN indicated they were not. The ICN was then asked if COVID monitoring was done based on assessing for new onset respiratory symptoms and stated that it was. The ICN was then asked what the rationale was for not testing a resident with new onset respiratory symptoms for COVID-19 was and stated, We go by what the doctor says. The doctor had concern for aspiration. There just wasn't concern for (R34) having COVID. They have history of pneumonia. The ICN was asked if there was any documentation explaining why COVID-19 was not ruled out for R34 or any documentation at all in the chart related to COVID-19 and R34 and indicated there was not. A review of R34's medical record revealed that the resident was last tested for COVID-19 on 8/19/20 with a negative result. A review of R34's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was admitted into the facility on [DATE] with medical [DIAGNOSES REDACTED]. Further review revealed the resident was moderately cognitively impaired and required extensive assistance from staff for activities of daily living. The MDS indicated the resident did not require oxygen therapy. Review of facility provided policy/procedure entitled, Surveillance for Healthcare-Associated Infections (dated 2/2018) revealed, The Infection Preventionalist will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and epidemiologically significant infections . Review of facility provided policy/procedure entitled, Infection Control (dated 01/20) revealed, The facility's infection prevention and control program (ICPC) is designed to provide a safe, sanitary and comfortable environment and to help prevent development and transmission of communi
F 0908 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Keep all essential equipment working safely.** Based on observation, interview, and record review, the facility failed to maintain the hand sink plumbing, the garbage grinder atmospheric vacuum breaker, the seal on the(NAME)cooler, and failed to ensure adequate lighting levels in the walk-in cooler, resulting in standing water on the floor, the potential for backflow of contaminants into the potable water supply, and the increased potential for improper food storage temperatures. These deficient practices had the potential to affect all residents in the facility. Findings include: On 9/15/20 between 8:30 AM and 9:30 AM, during an inspection of the kitchen with Dietary Manager (DM) O, the following items were observed: 1. The drain pipe for the hand washing sink was observed to be actively dripping water onto the floor. There was a small bucket underneath to catch the water, and there was water pooled on the flooring underneath. According to the 2013 FDA Food Code section 5-205.15 System Maintained in Good Repair, A plumbing system shall be: .(B) Maintained in good repair. 2. The atmospheric vacuum breaker (backflow prevention device) for the garbage grinder side sprayers, was observed to be missing the cap, leaving the inner workings of the device exposed. According to the 2013 FDA Food Code section 5-202.14 Backflow Prevention Device, Design Standard. A backflow or backsiphonage prevention device installed on a water supply system shall meet American Society of Sanitary Engineering (A.S.S.E.) standards for construction, installation, maintenance, inspection, and testing for that specific application and type of device. 3. The door on the left side of the(NAME)cooler was observed with a faulty seal. When closed, there were gaps between the door gasket and the front of the cooler. When queried, DM O stated, They just replaced the seal. He told me I have to hold it in for 10 seconds, and then it will seal. DM O tried to hold the door closed to ensure a seal, but the gasket still provided no seal against the unit. According to the 2013 FDA Food Code section 4-501.11 Good Repair and Proper Adjustment, .(B) Equipment components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. 4. The lighting levels inside the walk-in cooler were observed to be extremely dim. The bulbs inside the fluorescent light fixtures were observed to be dim and flickering, and there was a bulb missing in one of the light fixtures. DM O confirmed that the lighting levels were dim, and stated, I'll let maintenance know. According to the 2013 FDA Food Code, section 6-303.11 Intensity, The light intensity shall be: (A) At least 108 lux (10 foot candles) at a distance of 75 cm (30 inches) above the floor, in walk-in refrigeration units and dry food storage areas and in other areas and rooms during periods of cleaning;