STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235722	A. BUILDING _____ B. WING _____	07/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MISSION POINT NURSING AND REHAB CENTER OF HOLLY	**313 SHERWOOD ST HOLLY, MI 48442**

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 infection prevention and control standards for residents in droplet isolation precautions for three (R705, R706, and R707) of four residents reviewed for infection control and failed to wear a mask in an appropriate manner during a COVID-19 (Coronavirus Disease 2019) survey, resulting in the potential for spread of infection which had the potential to affect all 48 residents who resided in the facility. Findings include: On 7/21/20 at 9:35 AM, the Director of Nursing (DON) who was identified as the facility's Infection Control Preventionist was interviewed. The DON reported on 7/12/20 one resident tested positive for COVID-19 who resided on the observation unit (C hall and part of A hall - areas designated for residents who newly entered or re-entered the facility from a hospital or who had gone out for an appointment or leave of absence). As an added precaution, all residents who resided in the observation areas, were placed on droplet precautions and kept on the observation unit with increased monitoring of signs and symptoms of respiratory illness and COVID-19 to rule out any infection. On 7/21/20 at 9:55 AM, Staff C was observed at the front entrance screening a visitor for COVID-19 who entered the building. Staff C was observed to wear a gown, gloves, and a surgical mask that covered their mouth, but was not observed to cover their nose. At that time, Licensed Practical Nurse (LPN) A (Unit Manager) was asked if Staff C had their personal protective equipment (PPE) applied correctly and LPN A reported that it appeared correct. On 7/21/20 at 10:44 AM, the Director of Nursing (DON) was interviewed. When queried about the proper way to wear a surgical mask, the DON reported the only way to wear a mask is covering the mouth and over the nose. On 7/21/20 at 10:22 AM, an observation of the C Hall was conducted. Registered Nurse (RN) G was observed touching and arranging R706's bed sheets. RN G wore a surgical mask, no gloves and no gown. RN G was not observed to perform hand hygiene or change their mask upon exiting R706's room. A plastic bin that contained gowns and gloves was observed directly outside of R706's room. A sign on the bin noted to see the nurse for masks. At that time RN G was interviewed. When queried about the PPE bin located outside of R706's room and if the unit had any special isolation procedures, RN G reported that everyone on the hall had the PPE bins and stated, The residents are on this hall because if they went out to the hospital or to an appointment they have to be down here for 14 days. When queried about whether or not the residents were on isolation precautions, RN G stated, They are technically not on precautions. They don't have COVID. They are just down here to see if they have any symptoms. RN G reported they would only wear a gown or gloves if administering medications, feeding tube care, or wound care. RN G reported they wore the same surgical mask throughout the day unless they had to take it off for any reason. On 7/21/20 at 10:26 AM, Certified Nursing Assistant (CNA) H was observed inside of R707's room. CNA H was observed wearing a surgical mask, no gown, and no gloves and was at the foot of R707's bed holding on to the footboard. Upon exiting R707's room, CNA H was interviewed. When queried about the A Hall and if the residents were on any isolation precautions, CNA H stated, They basically made this a quarantine hall and residents who are new admits or go out and come back from the hospital have to stay here for 14 days. When queried about the PPE bins located outside of each residents' room, CNA H stated, Those have always been out there. CNA H reported they would wear a gown and gloves only when they provided care but not only when they entered the room. When queried about why, CNA H stated, Nobody (residents) have anything (infections). On 7/21/20 at 10:30 AM, a staff member was observed seated at a table inside of R705's room. R705 was seated on the other side of the table. The staff member was observed wearing a surgical mask, no gown, and no gloves. A PPE bin was observed outside of R705's room. Further observation of the C hall unit revealed that all rooms had PPE bins outside of the room and some rooms had signs on the doors that indicated Droplet Precautions. On 7/21/20 at approximately 10:35 AM, RN G was observed preparing medications on the A hall. When queried, RN G reported they were responsible for a series of rooms on the A hall in addition to the entire C hall (observation) unit. An observation of the A hall unit revealed five residents who were not on isolation precautions and one resident who had a sign for droplet precautions. On 7/21/20 at 10:44 AM, the DON was interviewed. When queried about what PPE was required when entering a residents' room who was on droplet precautions, the DON reported a surgical mask, gown, and gloves that should be removed before exiting the room and hand hygiene performed. The DON reported all of the rooms that had PPE bins outside of them were residents on droplet precautions. The DON reported the staff should change their surgical mask between each resident on droplet precautions. The above observations were discussed with the DON. The DON stated, The point of an observation unit is because you do not know if they are infected. R705's clinical record was reviewed and revealed R705 was readmitted into the facility on [DATE] from the hospital. R705 had a physician's orders [REDACTED]. R706's clinical record was reviewed and revealed R706 was admitted into the facility on [DATE] and readmitted [DATE]. R706 had a physician's orders [REDACTED]. R707's clinical record was reviewed and revealed R707 was admitted into the facility on [DATE]. R706 had a physician's orders [REDACTED]. A facility policy titled, Novel Coronavirus Prevention and Response (Revised 5/12/20) was reviewed and documented, .Interventions to prevent the introduction of respiratory germs into the facility .Consider a designated wing/unit or floor to accept new residents .Promote easy and correct use of personal protective equipment (PPE) by: .Posting signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE .Make PPE .available immediately outside of the resident's room .Implement procedures to identify and monitor others who may have been exposed if COVID-19 disease is confirmed . The facility reported they followed guidance from the Centers for Disease Control and Prevention (CDC) for determining isolation precautions and observation protocols for residents newly admitted or readmitted from the hospital or the community. The facility provided the following document titled, CDC - Coronavirus Disease 2019 (COVID-19) Preparing for COVID-19 in Nursing Homes (updated on 6/25/20) which documented the following: .HCP (Health Care Personnel) should wear a facemask at all times while they are in the facility .Have a plan for how roommates, other residents, and HCP who may have been exposed to an individual with COVID-19 will be handled .Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown .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. HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e. goggles or a face shield .), gloves, and gown when caring for residents .Evaluate and Manage residents with Symptoms of COVID-19 .Because of the higher risk of unrecognized infection among residents, universal use of all recommended PPE for the care of all residents on the affected unit .is recommended when even a single case among residents of HCP is newly identified in the facility .

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.