STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235355	A. BUILDING _____ B. WING _____	04/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MISSION POINT NSG & PHYSICAL REHAB CTR OF LAMONT	**13030 COMMERCIAL ST LAMONT, MI 49430**

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 properly implement infection prevention and control practices to prevent the potential for the development and transmission of COVID-19. Findings: An unannounced on-site investigation to conduct a COVID-19 Focused Survey began on 4/7/2020 at 8:15 AM. During an observation on 4/7/20 at 8:25 AM, Registered Nurse (RN) B was observed standing at the medication cart, a surgical mask was pulled down to her chin, not covering her mouth or nose. During an observation on 4/7/20 at 8:30 AM, Certified Dietary Manager (CDM) D was seen walking from the kitchen toward an office on the resident unit without wearing a mask. CDM D said she did not have a mask on because she had just gotten to work and had not yet put one on. During an observation on 4/7/20 at 8:33 AM, Resident #2 was observed seated in his wheelchair in his room. An assembled nebulizer machine (tubing and mouthpiece attached to machine) was observed sitting on the bedside table, without a protective barrier and was not stored in a plastic bag. It was not clear when the equipment was last used. Review of the electronic health record for Resident #2 reflected he readmitted to the facility on [DATE] after a hospitalization and had been diagnosed with [REDACTED]. The Medication Administration Record [REDACTED]. After allowing the dishwasher to warm up by running several cycles, the Thermolable did not register a sanitizing temperature of 160 degrees at the surface of the plate had been achieved as evidenced by a non-reactive (light gray) colored result. If the appropriate temperature had been reached, the Thermolable would have turned black. During an interview on 4/7/20 at 9:10 AM, CDM D reported that she would contact Maintenance Supervisor (MS) J to adjust the temperature booster (used to regulate water temperature supplied to the dishwasher). During an observation on 4/7/20 at 10:00 AM, MS J demonstrated the temperature test again using the 1-Temp Thermolable to prove the dishwasher was sanitizing dishes at the correct temperature. After two attempts, a thermolable attached to a plate did not register a surface temperature reading of 160 degrees as evidenced by a black box reaction on the test strip. After applying another test strip to a metal knife, the test strip registered a sanitizing surface temperature of 160 degrees. MS J said he would again adjust the temperature booster for the water supplied to the dishwasher. According to the 2013 FDA Model Food Code section 4-703.11 Hot Water and Chemical. After being cleaned, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED IN: (B) Hot water mechanical operations by being cycled through Equipment that is set up as specified under 4-501.15, 4-501.112, and 4-501.113 and achieving utensil surface temperature of 71 C (Celsius, 160 Fahrenheit) as measured by an irreversible registering temperature indicator; P. During an observation on 4/7/20 at 10:10 AM, Dietary Aide (DA) L was washing dishes and wearing a surgical mask on her chin, not covering her mouth or nose. DA L said the mask made her uncomfortable. At the same time the Cook, employee G was not wearing any surgical or cloth mask covering her mouth or nose as she began preparing the noon meal. During a telephone interview with the Director of Nursing/Nursing Home Administrator (DON/NHA) on 4/7/20 at 3:15 PM, she reported she was aware of new guidelines set forth by The Centers for Medicare and Medicaid Services (CMS) that directed all staff wear a mask at all times throughout the facility. The DON/NHA said her expectation is that all staff follow the guidelines set forth in a directive issued by CMS on 4/2/20 and wear a mask covering their mouth and nose at all times throughout the facility, not just clinical areas. The DON/NHA reported she considered the kitchen a fundamental resident contact point and would address the concerns identified to prevent the potential for the spread of COVID-19. The DON/NHA also addressed the nebulizer equipment observed in Resident #2's room stored inappropriately. The DON/NHA said that in order to avoid Aerosol Generating Procedures (AGP), whenever possible residents were switched to oral inhalers rather than nebulizer treatments. The DON/NHA reported that Resident #2 had not been on a nebulizer since he returned from the hospital a week prior to the observation and did not explain why the equipment was left on the bedside table. According to a facility policy titled, Respiratory Small Volume Nebulizer revised 2/2018 reflected, Cleaning and Storage: disassemble device and rinse/clean the mouthpiece and nebulizer cup and allow to dry thoroughly, each use. When dry, store equipment and tubing in clear plastic bag or proper clean storage per the facilities preference, marked with name and date . According to a CMS (Center for Medicare and Medicaid) document submitted by the facility titled, COVID-19 Long Term Care Facility Guidance dated 4/2/2020 reflected. Long term care facilities should ensure all staff are using appropriate PPE (personal protective equipment) when they are interacting with patients and residents to the extent PPE is avail and per CDC (Center for Disease Control and Prevention) guidance on conservation of PPE: for the duration of the state of emergency in their State, all long term care facility personnel should wear a facemask while they are 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.