STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235405	A. BUILDING _____ B. WING _____	09/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLINTON AIRE HEALTHCARE CENTER	17001 17 MILE RD CLINTON TOWNSHIP, MI 48038

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** - Some	**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 visitor restrictions and utilize Personal Protective Equipment (PPE) correctly for two residents (Resident #700 and #701) of three residents reviewed during a focused infection control survey, resulting in the likelihood of the spread of COVID-19 (a potentially serious respiratory infection). Findings include: On 9/3/2020 at 9:15 AM, Resident #701 was located on the Person Under Investigation (PUI) COVID-19 unit. According to the Director of Nursing (DON), the PUI unit was reserved for residents that had been new admissions from the hospital that required 14 day monitoring and isolation for COVID-19. Signs were posted on Resident #701's door indicating the need to wear PPE when entering the room. The sign further explained that the PPE needed was a gown, N95 mask, gloves and eye coverings. On 9/3/2020 at 9:44 AM, Resident #701 was observed lying in bed in their room. The door of the room was open. Resident #701 was talking to another resident (Resident #700) that was in their room (but not their roommate). Resident #700 was in their wheelchair approximately four feet from the doorway inside the room. Resident #700 had only a surgical mask on. During this time, this surveyor was speaking to the DON in the hallway and asked about Resident #700 visiting Resident #701 while Resident #701 was in isolation and monitoring for COVID-19. The DON explained that the two residents were friends and the situation was unique. The DON then explained to Resident #700 that they could not visit Resident #701 while the resident was in quarantine for 14 days. The DON also explained to Resident #700 that the door to Resident #701's room had to remain closed for the first 14 days upon admission and that anyone going in the room had to wear the proper PPE. Resident #700 then became upset and stated, Why? The nurse last night told me that as long as I was 6 foot apart and wore a mask that I could visit with (Resident #701)! A review of the medical record for Resident #701 revealed that the resident was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Resident #701 was a new admission from the hospital. A review of the care plan for Resident #701 revealed the following: Focus-I, (Resident #701) has potential for infection with COVID-19 virus r/t (related to) active community COVID-19 cases .(initiated 9/3/2020). Goal-I will remain free from infection . Interventions/Tasks-Implement and encourage physical/social distances. Encourage in-room or non-communal activities of choice . A record review of the progress notes for Resident #701 revealed the following: 9/3/2020 11:26 Nursing Note .This writer provided .education to resident regarding policy on new admissions. As per facility policy resident is required to remain in room with door shut for 14 days to monitor for s/s (signs and symptoms) of COVID19. During this time all care will be provided in room. Resident will not be able to have contact with residents from other areas of the facility during this time. If resident has a room-mate, social distancing will be encouraged. Resident stated they understood and agreed with facility policy On 9/3/2020 at 11:18 AM, Resident #700 was observed in their room dressed and groomed. Resident #700 was alert and oriented to person, place, time, and situation. Resident #700 was asked about the incident that occurred earlier that involved being in Resident #701's room and the DON. Resident #701 stated, My boyfriend came (to the facility) last night from the hospital. The nurse that was on duty walked by (Resident #701's) room and seen me at their bedside with my mask on helping them. I was trying to get (Resident #701) situated because no one was around to help. She (unidentified nurse) told me I could not be in there unless I was in the doorway. I went down there this morning, and a new nurse (DON) told me I could not go in there today because they were in quarantine. They should have nipped that in the butt last night. If that nurse would have told me the rules last night I would have never went in there. My boyfriend's roommate is supposed to be in quarantine and walks up and down the hall. They moved me (just now) because they caught me talking outside of the door today with a mask on. So now, I have to be quarantined and I don't want to deal with this crap, now I can't leave this room or participate in activities for two weeks. It was not my job to stop me, it was their (the facility) to stop me last night! Now people have to wear plastic wrap to see me . A record review of the progress notes for Resident #700 revealed the following: 9/3/2020 11:43 Social Services Note .SW (Social Worker) did do to resident's room today as (Resident #700) was extremely upset as they feel why (Resident #700) was able to converse with their boyfriend that was a recent admission. SW did attempt to calm resident down and indicate to them that there is a 14 day quarantine period for all new admission. Resident would like to speak to Infection Control Nurse. 9/3/2020 12:02 Nursing Note .Resident (#700) in room [ROOM NUMBER] in wheelchair. Resident at bedside of 300-2 (Resident #701). Resident (#700) stated that resident in 300-2 is their boyfriend and was visiting. Writer reinforced teaching to resident that they could not be in room due to the room being on quarantine for 14 days .reinforced education to resident that they should not be in the hallways and that mask be worn when not in room. Resident (#700). was then escorted out of the room. A record review of the Resident/Family Education Record dated 9/3/2020 for Resident #700 revealed that the resident was educated on All new admissions are isolated for 14 days. During this time period no visitors are allowed. At this time resident is unable to visit with her boyfriend r/t risk of exposure. A record review of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #700 was admitted to the facility on [DATE] following a hospital stay. Resident #700 had the [DIAGNOSES REDACTED].#700 had an intact cognition. On 9/3/2020 at 2:06 PM, Infection Control Preventionist (ICP) A was queried in regard to the visitation policy of the facility and stated, End of life can get visits, we allow hospice, nurses, labs, xrays, psych and ancillary services in. The ICP was queried regarding Resident #700 visiting with Resident #701 earlier. The ICP explained that Resident #700 was educated about quarantine and visitation after the incident. A review of the COVID-19 policy effective August 24, 2020 revealed the following: Post signs instructing visitors that visitation is restricted at this time due to the potential spread of COVID-19 .In lieu of visits, the facility should create avenues for communication, i.e., video communications, letters, phone calls, etc.

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