STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235357	A. BUILDING _____ B. WING _____	09/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MISSION POINT NSG & PHYSICAL REHAB CTR OF BELDING	414 E STATE ST BELDING, MI 48809

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 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure prompt review of pharmacy medication recommendation reports for two residents (Resident #49 and Resident #31), resulting in the potential for Adverse Drug Reactions (ADR) due to unresolved medication-related problems, medication errors and other irregularities that were not addressed by the Physician/prescriber despite pharmacy oversite. Findings: Resident #49 Resident #49 was admitted to the facility 11/13/19, with [DIAGNOSES REDACTED]. Review of the Electronic Medical Record (EMR) for Resident #49 reflected a Pharmacy Progress Note dated 7/27/20 at 3:36 PM. This entry reflected, .Monthly medication regimen review performed. The entry reflected a, Potential irregularity. See report for physician recommendation. Review of the EMR list of Pharmacy documents revealed reports dated 6/8/20 and 8/31/20, but no report of the 7/27/20 review was found. This indicated that the report had not been available for physician review of the potential irregularity of the Resident's medication regimen. On 9/24/20 at 12:30 PM, an undated Pharmacy Report obtained by the Director of Nursing (DON) was reviewed. The DON reported this document is the Pharmacy Medication Review referenced in the Progress Note on 7/27/20. The document reflected a pharmacist recommendation to discontinue the medications atorvastatin (aka [MEDICATION NAME]) and tamsulosin. The document did not reflect the pharmacist's recommendations had been reviewed by the physician. The DON reported that the medical provider did not see this pharmacist's report. Review of the Pharmacy Progress Note for 8/31/20, reflected the consulting pharmacist met directly with the medical provider regarding the medication recommendations of 7/27/20. The Progress Note reflected the medical provider agreed with the consulting pharmacist and indicated the medication should be discontinued. Review of the Doctor's Orders reflected the medications atorvastatin (aka [MEDICATION NAME]) and tamsulosin had been discontinued 8/31/20. This medication change occurred almost five weeks after the irregularity was first identified. During the encounter on 9/24/20 at 12:30 PM, when discussing the system for timely pharmacy medication reviews, the DON had stated, we have a good system. However, the DON did not indicate why a pharmacist-recommended medication report had not been addressed for almost five weeks. Resident #31 Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected Resident #31 admitted to the facility on [DATE] and was severely cognitively impaired and needed extensive assistance from two people for bed mobility, dressing, toilet use and personal hygiene. Section N-Medications of the MDS reflected Resident #31 had taken an antipsychotic, antianxiety and opioid medication every day of the 7 day look back period. Review of a Pharmacy Progress Note dated 7/23/2020 at 16:20 reflected a Monthly Medication Review (MMR) had been conducted by the pharmacist for Resident #31 and indicated recent labs (A1c, a measure of blood glucose control) had been reviewed and a Potential irregularity found. See report for physician recommendation. The progress note did not specify what the nature of the irregularity was. Review of Resident #31's Electronic Medical Record (EMR) for the pharmacist's report pertaining to a potential irregularity to be addressed by the prescriber was unsuccessful., the report and follow-up could not be found. During an interview on 9/24/20 at 10:56 AM, the pharmacist's Irregularity report referenced in the pharmacy progress note dated 7/23/20 and physician follow up was requested from the Director of Nursing (DON). The DON attempted to locate the records in the EMR and they were not found. The DON reported she would find out where they were and follow-up with this surveyor. During a follow-up interview on 9/24/20 at 12:30 PM, the DON provided an undated copy of the pharmacy irregularity report that was printed on 9/24/20 and was not signed/addressed by the Physician/Prescriber. The DON also shared a copy of an email sent by the pharmacist on 7/29/2020 at 11:50 AM titled Consultant Pharmacist Recommendations - July 2020 and explained that each month the pharmacist will send an email to the DON and attach the recommendation/irregularity reports to be distributed to and reviewed by the Physician/prescriber. However, the pharmacist did not attach the recommendation reports to the email sent on 7/29/2020 and the DON and two other recipients did not recognize the omission. Review of the undated Note to Attending Physician/Prescriber indicated that Resident #31 was started on [MEDICATION NAME] 10 mg daily for itching on 5/13/20. The Pharmacist asked the prescriber to please consider discontinuing this medication if the issue (cause of itching) has resolved.
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 ensure aspects of its Infection Prevention and Control program were consistently implemented resulting in a pattern of breaks in Transmission Based Precautions (TBP) related to extended use of Personal Protective Equipment (PPE) for 3 residents (Resident #63, #80 and #55); and when one staff member did not correctly perform hand hygiene during meal service on a different unit; and when dietary staff did not correctly disinfect a meal tray delivery cart for residents who were in droplet contact isolation precautions resulting in the potential for cross contamination and complications from being sickened with infectious disease. Findings: Resident #63 Review of an Admission Record reflected Resident #63 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Nursing Progress Notes documented on 9/7/2020, Resident #63 had an unwitnessed fall in her room, sustained a hematoma on her head and was sent to a local hospital for evaluation, returning a few hours later after no serious complications from the fall were identified. The progress notes indicated Resident #31 was returned to an observation room for 2 weeks because of her potential risk for (Covid-19) exposure while being assessed at the hospital. During an observation on 9/21/20 at 11:21 AM, a sign outside Resident #63's room indicated she admitted to the observation room on 9/7/20 with precautions being discontinued on 9/21/20. Registered Nurse (RN) Q was observed entering Resident #63's room, donned gloves and a washable isolation gown that hung on a hook inside the room behind a red line taped to the floor. RN Q was already wearing a surgical mask and glasses that she covered with goggles. RN Q opened the drawers of the PPE towers situated inside the door of Resident #63's room. No additional washable isolation gowns were seen and RN Q said the green disposable gowns were for the resident in case she needed to leave the room. No N-95 masks were observed and RN Q reported she did not need to wear an N-95 mask while assisting Resident #63 and reported the decision had been made to stop using the N-95 masks on a corporate level some time ago. RN Q finished providing assistance for Resident #63, doffed the isolation gown and hung it on a hook on the wall, doffed the goggles and replaced them on a hook without cleaning them, removed and discarded the gloves, performed hand hygiene and left the room. Review of a Care Plan initiated on 9/7/2020 indicated Resident #63 was At risk for hosting and/or unknowingly transmitting COVID-19 related to being evaluated at (hospital). Interventions on the care plan included I am on droplet precautions for at least 14 days during my observation period; Encourage me to keep my door closed during the observation period; Encourage me to wear a masks during close contact with staff, a cloth mask is fine. The care plan was Resolved on 9/21/20 due to Resident #63 had met the 14 day obligation without evidence of signs or

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.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) symptoms of COVID-19. Resident #80 Review of an Admission Record reflected Resident #80 originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During an observation outside Resident #80's room on 9/21/20 at 11:00 AM, a sign was posted indicating Resident #80 admitted to the observation room on 9/13/20 and would be released from observation room on 9/27/20. Certified Nurse Aide (CNA) N was observed responding to Resident #80's call light, entered the room through the open door wearing a surgical mask, donned gloves then a washable gown that hung on a hook on the wall in Resident #80's room and closed the door to provide privacy as she assisted Resident #80. Upon leaving Resident #80's room, CNA N reported staff are assigned a washable gown at the start of their shift, one for the CNA, one for the Nurse and other staff were not allowed to wear the gowns that were hanging in the room and would have to get a disposable or a different washable gown in order to provide care. CNA N said she wore an N-95 mask while caring for Resident #80, however this surveyor did not observe the mask donning or doffing. During a follow-up interview on 9/21/20 at 11:30 AM, CNA N was again asked if she wore an N-95 when caring for residents in observation rooms requiring droplet precautions and if so, how did she store and handle the mask between residents. CNA N maintained that she wore an N-95 earlier while providing assistance to Resident #80, and would store it in a plastic baggie but learned from other staff that N-95's were not being used. CNA N said she took her used N-95 to the employee break room and threw it away. During an observation on 9/21/2020 at 12:18 PM, CNA R was observed entering Resident #80's room to deliver a meal tray, awkwardly donning the same isolation gown worn by CNA N earlier while balancing a meal tray, did not don goggles over her glasses and did not secure the ties of the washable isolation gown before attending to the resident at the bedside. During an interview on 9/22/20 at 12:42 PM, the Assistant Director of Nursing/ Infection Control Nurse RN A reported that staff caring for residents in observation status did not wear N-95 masks because only residents who test negative for COVID-19 are admitted to the facility and because they did not have a lot of N-95 masks left. RN A said the facility would not admit a resident with a negative COVID-19 test that was greater than 72 hours old (prior to admission). RN A said even with the negative COVID-19 test result it would be impossible to guarantee potential exposure to [MEDICAL CONDITION] did not occur prior to the resident coming to live at the facility. RN A was asked to provide COVID-19 specific infection control policies and procedures, including transmission based precautions and policy related to conservation of PPE or the extended or re-use of PPE that is in short supply. During an interview on 9/23/2020 at 3:17 PM, The Director of Nursing and RN A reviewed policies and rational for implementing reusable PPE strategies to conserve supplies of necessary PPE due to limited availability. Review of an undated Reusable PPE Guideline posted in each of the observation unit rooms, staff donning reusable isolation gowns in rooms where contact precautions were indicated were to keep the dirty side away from their body, and put both arms in the sleeves in a swim like fashion. Staff were also to don a face shield or goggles and clean after use. The Reusable PPE Guideline did not reference what type of mask and how to manage mask use between resident rooms. During an observation and interview from the hall on 9/24/20 at approximately 9:55 AM, Resident #55 and Resident #80's door was closed and had an isolation sign on the door. RN U and CNA S stated, Resident #55 and Resident #80 were both in transmission-based precautions for either a new admission or return from the hospital/outside appointment. RN U and CNA S stated they are required to don a gown, eye cover, gloves and a surgical facemask when entering the room. When asked if it was required to wear a N-95 both staff members stated, no, just the surgical. This practice does not follow the CMS guidance to use a N-95 for new/readmission residents whom COVID-19 status is unknown. On 9/21/20 at 12:15 PM, a review was conducted of the noon Dining Service on the S -1 Unit. During the service, an enclosed meal cart containing food trays was delivered to the S-1 Dining Room. Approximately eight residents were seated in this Dining area. A hand hygiene station was readily available in the Dining Room. Licensed Practical Nurse (LPN) B assisted in the delivery of resident food trays from the cart and then set up the meals for each resident. LPN B performed this task four times without performing hand hygiene. At one-point LPN B was observed putting her finger into her ear before removing a food tray and delivering it to a resident. The policy titled Hand Hygiene, last revised 12/19, provided by the facility was reviewed. The policy reflected, 1. Staff will perform hand hygiene when indicated, using proper technique with accepted standards of practice. Attached to the facility policy were sign sheets of an in-service dated 7/20/20, titled, Purpose: Hand Hygiene. The signature of LPN B , noted on the sign sheet, reflected the nurse had participated in the training. During an interview conducted 9/24/20 at 1:15 PM, the above observation was discussed with Infection Control Registered Nurse (ICRN) A. ICRN A reported staff are expected to perform hand hygiene after each tray passed. ICRN A reported staff have received frequent training on hand hygiene and that hand sanitizing stations are readily accessible in the S-1 Dining area. On 9/22/20 at 12:09 PM, Certified Nurse Assistant (CNA) S was observed to deliver a meal tray to Resident #19, who was under isolated observations for COVID19 monitoring. The tray was observed to not have any single-use paper products (i.e. paper tray, styrofoam cups, paper plates). On 9/22/20 at 12:16 PM, Director of Nutritional Services (DNS) T was queried on how the dishware, from the isolated observation rooms, is collected and cleaned. DNS T stated that the meal trays and dishware from the observation rooms are collected and put on the metal rollaway cart, just as the trays from the non-observation are collected, and then the carts are brought to the dish room. DNS T also stated that the trays are ran through the dish machine, then the carts are washed, rinsed, and sanitized. On 9/22/20 at 12:41 PM, Registered Nurse (RN) I was observed to gown up to retrieve the tray from Resident # 55. RN I called over CNA S and handed her the tray in the doorway. CNA S was then observed to place the meal tray inside the metal cart. During an interview on 9/22/20 at 1:10 PM, DNS T was queried on the cleaning procedure for the meal carts and stated that they are cleaned in place using a wash, rinse, and sanitize wiping cloths. DNS T also stated that the sanitizer used was Quaternary Ammonia. At the time of the interview, the dietary staff were emptying the trays from the cart and the wiping cloth buckets were being prepared to clean the carts. A Dietary Staff member was observed by the Surveyor and DNS T to test the concentration of the Quaternary Ammonia using color changing test strips. The test strips were observed to show the Quaternary Ammonia concentration at 200 pm. According to the Manufacturer's Directions for Use for disinfecting using the Quaternary Ammonia, it states, DISINFECTION - To disinfect inanimate, hard, non-porous surfaces add 1-2 ounces of this product per gallon of water (~ 700 pm) During an interview on 9/23/20 at 5:00 PM, DON and Infection Control Nurse A were informed of the meal carts being Sanitized at 200 pm and not properly disinfected at ~700 pm and were unaware of the issue.