STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235023	A. BUILDING _____ B. WING _____	05/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-BATTLE CREEK	200 E ROOSEVELT BATTLE CREEK, MI 49017

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 1) have a plan that included early detection and management of potentially infectious, symptomatic residents, 2) actively assess and monitor six residents for signs and symptoms of COVID-19 (Resident #1, #2, #3, #4, #5, #6) of six reviewed, 3) maintain evidence of complete and thorough staff screening for COVID-19, and 4) ensure knowledge of proper cleaning procedures for housekeeping staff to effectively disinfect dangerous pathogens, resulting in the potential for failure of early detection, unidentified staff illness and inadvertent potential of COVID-19 to all 50 residents and staff. Findings include: Review of the Centers for Disease Control and Prevention's (CDC) Key Strategies to Prepare for COVID-19 in Long Term Care Facilities (LTCFs) revealed Identify infections early: Actively screen all residents daily for fever and symptoms of COVID-19; if symptomatic, immediately isolate and implement appropriate Transmission-Based Precautions. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html) Review of the CDC's Preparing for COVID-19 in Nursing Homes, revealed Evaluate and Manage Healthcare Personnel .Screen all HCP (Healthcare Personnel) at the beginning of their shift for fever and symptoms of COVID-19. Actively take their temperature and document absence of symptoms consistent with COVID-19 .Fever is either measured temperature >100.0 F or subjective fever. Note that fever may be intermittent or may not be present in some individuals, such as those who are elderly, immunosuppressed or taking certain medications (e.g., NSAIDs) .HCP who work in multiple locations may pose higher risk and should be encouraged to tell facilities if they have had exposure to other facilities with recognized COVID-19 cases .Ask residents to report if they feel feverish or have symptoms consistent with COVID-19. Actively monitor all residents upon admission and at least daily for fever (temperature greater than or equal to 100.0 F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions .Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >99.0 F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html)?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html) According to the CDC, People with COVID-19 have had a wide range of symptoms reported-ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to [MEDICAL CONDITION]. People with these symptoms may have COVID-19: -fever or chills -cough -shortness of breath or difficulty breathing -fatigue -muscle or body aches -headache -new loss of taste or smell -sore throat -congestion or runny nose -nausea or vomiting -diarrhea (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html) Resident #1 (R1) Review of the medical record revealed R1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R1's medical record failed to reveal that she was assessed or monitored daily for signs and symptoms, other than fever, of COVID-19. Resident #2 (R2) Review of the medical record revealed R2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R2's most recent respiratory note was dated 5/6/20. There was no further documentation that R2 was monitored daily for signs and symptoms, other than fever, of COVID-19. Review of the Staff Screening Logs dated 5/18/20 through 5/28/20, revealed the following columns: - Employee name (last, first, initial) - Assigned area (unit/department) - No temperature - Temperature greater than or equal to 99.0 F but less than 100.4 F - Temperature greater than or equal to 100.4 F - No signs/symptoms (dry cough, shortness of breath) - Referral The directions for the log revealed Enter employee name and department. Verify no temperature or range, no signs and symptoms present (dry cough, shortness of breath) and place a (checkmark) in box . Further review of the Staff Screening Logs revealed the following: - On 5/18/20, 22 staff members did not have a checkmark in the no signs/symptoms box - On 5/19/20, 15 staff members did not have a checkmark in the no signs/symptoms box - On 5/20/20, 15 staff members did not have a checkmark in the no signs/symptoms box - On 5/21/20, 10 staff members did not have a checkmark in the no signs/symptoms box and 1 staff member did not have a temperature documented - On 5/22/20, 16 staff members did not have a checkmark in the no signs/symptoms box - An undated sheet scanned between 5/22 and 5/23 revealed 4 staff members did not have a checkmark in the no signs/symptoms box - On 5/23/20, 7 staff members did not have a checkmark in the no signs/symptoms box - On 5/24/20, 14 staff members did not have a checkmark in the no signs/symptoms box - On 5/25/20, 24 staff members did not have a checkmark in the no signs/symptoms box and 1 staff member did not have a temperature documented - On 5/26/20, 20 staff members did not have a checkmark in the no signs/symptoms box - On 5/27/20, 26 staff members did not have a checkmark in the no signs/symptoms box and 1 staff member did not have a temperature documented - On 5/28/20, 9 staff members did not have a checkmark in the no signs/symptoms box In a telephone interview on 5/29/20 at 11:16 AM with Nursing Home Administrator (NHA) A, Licensed Practical Nurse (LPN) L, and Interim Unit Manager/Registered Nurse (RN) M, it was reported the facility considered a temperature elevated when it reached 99.0 F and if a staff member had a temperature of 100.4 F, they would not be allowed to enter the building. When asked how the completed staff screening logs were monitored, NHA A reported the logs were given to Director of Nursing (DON) B. (DON B was not working on 5/29/20 and told survey staff to interview LPN L AND RN M). When asked about the incomplete staff screening logs, NHA A reported she did not have an explanation as to why each column was not filled out. When asked about resident monitoring, NHA A, LPN L, and RN M reported temperatures were checked every shift and if the temperature was over 99.0 F, the temperature was rechecked. NHA A, LPN L and RN M reported if a resident's temperature were over 100.4 F, staff would notify the medical director, physician, and do a respiratory assessment. NHA A, LPN L, and RN M were not aware that CDC changed the temperature from 100.4 F to 100.0 F. When asked if residents were only getting a full respiratory assessment if the temperature was over 100.4 F, they stated yes. When asked how residents were being monitored for other signs and symptoms such as sore throat, cough, headache, etc, NHA A stated we have different tiers and reported residents only get the assessment for additional symptoms if they have a temperature over 99.0 F. When asked about the all staff bulletin regarding respiratory assessments, dated 4/21/20, NHA A reported that memo was when the facility was a tier 2 and it was left up for something extra, but the full respiratory assessments on every resident were not being done because nobody is symptomatic. When asked if they were aware the CDC recommended all residents were monitored for signs and symptoms of COVID-19, NHA A reported the facility was following the tier 1 guidance they had (from their corporate office). Review of the facility's COVID-19 Clinical Monitoring and Measures Plan Enhanced Clinical Measures and Monitoring (Tier 1) effective 3/13/20, revealed the monitoring plan had not been updated to reflect the change of temperature from 100.4 F to 100.0 F per CDC recommendations. The plan revealed Complete Respiratory Surveillance UDA in (name of electronic medical record system) daily for all patients. Review of the Attention All Staff memo dated 4/21/20, revealed Things we are doing to help prevent/limit the exposure of COVID-19 in our facility For the Residents: Temperatures (every) shift on ALL residents Temperatures above 99.0 are to be retaken FULL respiratory assessment daily on ALL residents (Respiratory Surveillance

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** - Many	(continued... from page 1) under assessments) (location in the electronic medical record). Review of a master copy of the facility's Respiratory Surveillance (an available assessment in the electronic medical record) revealed the following observations/assessments available: most recent temperature, most recent blood pressure, most recent O2 sats, cough present, shortness of breath present, lung sounds, sore throat present, body aches present, headache present, loss of taste, loss of smell, presence of nausea, vomiting, diarrhea, is the patient in airborne respiratory isolation, and additional notes. On 5/28/19 at 09:08 AM when asked what type of COVID-19 parameters were in place for residents, the Director Of Nursing (DON B) revealed that newly admitted residents and residents returning from the hospital were isolated for 14 days. Residents with a negative COVID-19 test and signs/symptoms for 72 hours would go into quarantine. All other residents were considered to be on droplet precautions and N95 mask and gowns were used. The designated area for those residents according to DON B were rooms 25 through 32 on Hall 4. Later the same day at 11:50 PM DON B was asked how often were residents checked for signs/symptoms of COVID-19. DON B revealed, if a resident had a temperature above 99.0 degrees Fahrenheit (F) they would do a Respiratory Surveillance Assessments (RSA) on the resident. If a resident had a temperature above 100.4F, the resident would be placed on droplet precautions and RSA's would be done on the entire facility. Review of the facility's Respiratory Surveillance - V4 form reflected the following areas for assessment: 1. Most recent temperature 2. Most recent blood pressure 3. Most recent oxygen saturation (O2) saturation 4. Cough present 5. Shortness of breath 6a. Right upper lobe 6b. Right lower lobe 6c. Left upper lobe 6d. Left lower lobe 7. Sore throat present 8. Body aches present 9. Headache present 10. Loss of taste 11. Loss of smell 12. Presence of nausea, vomiting, diarrhea (check all that apply) 13. Is the patient in airborne respiratory isolation 14. Additional notes While touring the halls at 12:10 PM, none of the staff were observed wearing N95 mask. No Protective Personal Equipment signs and/or notices were noted on any residents's door to indicate they were on any type of isolation. Resident #5 (R5) According to the Electronic Medical Record (EMR) on 5/28/20 at 10:30 AM, R5 was admitted to the facility on [DATE] at 04:37 PM. However, from 5/19/20 to 5/29/20 no RSA were performed to monitor R5 for respiratory signs/symptoms (s/s) related to COVID-19. Also, based on the EMR the facility did not consistently check R5's temperature daily on every shift, and no documentation was noted for 72 hours or 14 days reflecting R5 was on isolation/quarantined. Resident # 6 (R6) The EMR for R6 revealed she was originally admitted to the facility on [DATE] and re-admitted to the facility on [DATE]. Temperatures for R6 reflected: 4/29/20 at 2:50 PM 99.2 degrees Fahrenheit (F), at 5:39 PM 101.2F and at 5:44 PM 101.2F. Respiratory surveillance assessments were performed on 4/29/20, 4/30/20, 5/1/20 and 5/3/20. However, no other daily RSA's were noted completed to monitor R6 for respiratory s/s related to COVID-19. Also, based on the EMR the facility did not consistently check R6's temperature daily on every shift, and no documentation was noted for 14 days reflecting the type of isolation was placed on. Resident #3 (R3) Review of the medical record, on 5/28/2020, reflected that R3 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On 5/22/2020 at 11:40 AM, R3's temperature was recorded as 99.1 degrees Fahrenheit. On 5/23/2020 at 2:40 AM, R3's temperature was 99.0 degrees Fahrenheit. On 5/23/2020 at 4:42 AM, R3's temperature was recorded as 99.0 degrees Fahrenheit. R3's most recent Respiratory Surveillance was dated for 5/22/2020 at 4:55 AM. R3's medical record did not reflect evidence that they were monitored daily for signs and symptoms, other than fever, of COVID-19. Resident #4 (R4) Review of the medical record, on 5/28/2020, reflected that R4 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. R4's medical record did not reflect any Respiratory Surveillance forms. R4's medical record failed to reflect that they were assessed or monitored daily for signs and symptoms, other than fever, of COVID-19. On 05/28/20 at 10:30 AM, Housekeeper C was observed to be doing environmental cleaning of resident room # 32 and was using Peroxide Multi-Surface Cleaner and Disinfectant (EPA registration # 1677-238). Housekeeper C was queried on the cleaner contact time to disinfect surfaces and stated that she thought it was ten or thirty seconds and continued to say, I'm not positive. During an interview on 05/28/20 at 10:50 AM, Housekeeper D was observed to be cleaning a resident room and was queried on the cleaning product that was being used and she stated it was Peroxide Multi-Surface Cleaner and Disinfectant for all of the hard surfaces. Housekeeper D was queried on the cleaners contact time to disinfect surfaces and stated that she was not 100% sure but think it works instantly. During an interview on 05/28/20 at 10:55 AM, Environmental Services Supervisor (ESS) E was asked about the contact time of the Peroxide Multi-Surface Cleaner and Disinfectant and stated that the contact time was three minutes. ESS E was informed of the housekeeping staff not knowing the contact time for the Peroxide Multi-Surface Cleaner and Disinfectant and ESS E stated that the housekeeping staff know the contact time for the cleaner and that they have been trained on it. ESS E stated that the Peroxide Multi-Surface Cleaner and Disinfectant would be the product used to disinfect surfaces of rooms that have suspected or confirmed cases of COVID-19. ESS E was queried on auditing the housekeeping staff on cleaning practices and stated that the housekeeping staff are not audited during the cleaning process, but the rooms are checked for cleanliness after the housekeeping staff are done cleaning. According the Peroxide Multi-Surface Cleaner and Disinfectant Manufacturer features for the products, it states, Effective On/Against: Variety of surfaces, including streak-free performance on glass Kills Norovirus in as little as 45 seconds (1) Kills Influenza A and B virus, Salmonella [MEDICATION NAME],[MEDICAL CONDITIONS].Canine Parvovirus, among other organisms (4) in 3-5 minutes (1)When diluted at 6 oz./gal (2) 3 minute kill time when diluted at 6 oz./gal; 5 minute kill time when diluted at 4 oz./gal per label instructions (3) PMSCD is effective against all three levels of emerging [MEDICAL CONDITION] pathogens based on difficulty level of kill, and can be used once the CDC has declared an outbreak (4) Refer to EPA master label under #1677-238