STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235175	A. BUILDING _____ B. WING _____	04/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF FRANKENMUTH	500 W GENESEE FRANKENMUTH, MI 48734

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(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** This citation pertains to MI 365. Based on observation, interview, and record review, the facility failed to perform monthly analysis on infection surveillance, maintain infection line listing according to standards of practice, provide appropriate personal protection equipment, monitor residents consistently for COVID-19, provide education and communication consistently to employees regarding COVID-19, implement respiratory care plans resulting in the potential to prevent the transmission of COVID-19 and other communicable diseases affecting all 67 residents of the facility. Findings include: The line listing and monthly analysis/summary for February 2020 was requested. The February 2020 line listing provided was titled Antibiotic Usage. During a telephone interview on 4/2/2020 beginning at 2:15 PM, the Infection Preventionist, Registered Nurse (RN) D, was asked if she utilized criteria for monitoring infections, and she stated that she used the McGeer's criteria for defining infections, but she had been told to print an antibiotic report. The undated Infection Summary-February, stated There were a total of 28 infections (14 skin, 3 respiratory, 5 UTI'S, 1 GI, and 5 other) . These were the numbers on the Antibiotic Usage report if the antibiotics that began in January 2020 and continued into February and the newly admitted residents on antibiotics were included on the Summary report. Therefore, the monthly facility acquired infection rate could not be calculated from the data provided, thus, the facility rate could not be calculated and compared from month to month. To calculate a facility infection rate, the number of new, in-house acquired infections for the month are divided by the number of resident days in that month. The resident days number is the addition of the facility census for each day of the month. By including carry overs, these were not new infections for the month of February. The residents who were newly admitted with an infection were not acquired in the facility. The Infection Summary-February report stated that Infection rates have shown improvement (respiratory) or remained stable (UTI'S, other), except for GI which increased by 1 and skin infections which increased by 4. These numbers did match up if the numbers on the :Antibiotic Usage report if the numbers included residents who were carry overs from January and the residents newly admitted with antibiotics were included. RN D was asked if she calculated a facility acquired infection rate and answered no, although the computer was capable of doing that calculation. RN D stated that she usually looked at data for the month, but did not compare historical rates for more than three months. RN D stated that the computer was able to put the data on a graph, but she did not do that. RN D stated she did not keep a written list of residents with indwelling urinary catheters, residents with infections of antibiotic resistant residents, or residents who had clostridiodes difficle infections. RN D stated that not everyone on the Antibiotic Usage list had met the criteria for an infection. On the March 2020 resident line listing of infections, there were no signs or symptoms of infections recorded and there were no organisms recorded for infections listed for any resident entry listed. Not all of the residents listed had room numbers. Resident #1 On the March 2020 resident line listing of infections, Resident #1's name and the incorrect acute care facility was listed. The room number, bed assignment, admitted , the onset date, infection category, organism, x-ray date, medication, resolved date, and general comments columns were blank. Resident #1 was not on the February line listing for a respiratory infection, even though he had been sent to the hospital where he had been diagnosed with [REDACTED]. According to the Admission Record, printed on 4/1/2020, Resident #1 was a [AGE] year old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to a progress note, Resident #1 had been sent to the hospital on [DATE] with an elevated temperature of 100.7, and elevated pulse of 134, and an elevated blood sugar of 504. Resident #1 returned to the facility on [DATE] where he had been diagnosed with [REDACTED]. According to a progress note, on 3/19/2020, Resident #1 returned to the hospital with an elevated pulse of 111, and elevated temperature of 100.8, an oxygen saturation of 91%, abnormal lung sounds with crackles in the left lower lobe and diminished sounds in the lower right lobe, nausea, dry heaves, and a decreased level of consciousness. The progress notes indicated that Resident #1 returned from the hospital on [DATE] with a [DIAGNOSES REDACTED]. Resident #1 continued to have a mild fever and was administered [MEDICATION NAME]. According to the hospital records, Resident #1 had a COVID-19 Screening on 3/20/2020. The first response was Able to assess patient. The first question was Have you had a fever of 100.1 and symptoms of a lower respiratory illness (cough, difficulty breathing, etc,)? This question was answered No(1). However, on the same date in the hospital, 3/20/2020, the physician documented that Resident #1 was sent to the hospital with [MEDICAL CONDITION] and an oxygen saturation rate of 87%. [MEDICAL CONDITION] is a low level of oxygen in the blood and usually results in difficulty breathing and an elevated respiratory rate as the person breathes faster to increase oxygen levels. The physician then documented that Resident #1 had a temperature of 100.1 and a cough. This directly contradicted the information answered on the COVID-19 screen. During a telephone interview on 4/2/2020 that began at 9:15 AM, RN D was asked what she thought it meant that the hospital was able to assess when Resident #1 had a facility care plan, dated 4/30/2018, that identified Resident #1 as having difficulty making decisions and was confused. RN D was also asked if she thought Resident #1 had answered the questions on the COVID-19 screen. RN D stated she could not speak to what the hospital did. RN D was asked if she had contacted anyone at the hospital to question them regarding the COVID-19 screen. RN D stated that she had contact with the hospital before Resident #1 returned. When asked who she had spoken to, she stated that she had not spoken to anyone, but relied on the paperwork sent to the facility by the request of the facility's medical records department. RN D stated that the hospital was not investigating Resident #1 for COVID-19. When asked again who she spoke to, RN D reiterated that it was in the paperwork from the hospital, that she had not called the hospital for clarification. During a review of the care plan in the EMR on 4/1/2020, Resident #1 had no plan of care that focused on respiratory concerns or infections, or interventions for respiratory concerns or infections even though he had been diagnosed with [REDACTED].#3 During a telephone interview with RN D on 4/2/2020, RN D stated that the room mate of Resident #1, Resident #3, had been placed in isolation on droplet precautions on 3/19/2020 by RN L who had been on-call and in the building when Resident #1 had become acutely ill and sent to the hospital. On 3/23/2020, in consultation with corporate RN O, who made the determination, Resident #3 was taken off of isolation precautions based on the paperwork received from the hospital. Resident #3 had a full set of vital signs taken and recorded on the Medication Administration Record (MAR) on 3/19/2020, then that order was discontinued and a checkmark was placed on the MAR for vital signs twice a day from 3/19 to 31/2020. Resident #3's temperature had not been recorded on the Vital Signs section of the electronic medical record (EMAR) on 3/26/2020, 3/29/2020, or 3/31/2020. During a review of the care plan in the EMR on 4/1/2020, Resident #3 had no care plan that focused on isolation for droplet precautions. This was confirmed by RN D during the telephone interview on 4/2/2020. During a telephone interview with RN L on 4/2/2020 beginning at 11:30 AM, she stated that Resident #1 had been sent to the hospital around 4:30 PM, sometime before supper on 3/19/2020. She stated that she had called RN D who called her back after she spoke with corporate RN O. RN L stated at that time she was instructed to place Resident #3 on droplet precautions for isolation and she prepared the PPE and placed it by his room. She then instructed the staff to gown up and keep the door to his room closed. RN L stated she did not observe anyone entering his room or putting on the PPE. RN L stated that there had been an inservice three to four weeks ago with a demonstration of putting on and removing PPE. On 4/1/2020 at 5:00 PM, a telephone interview was conducted with Licensed

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) Practical Nurse (LPN) F. LPN F stated they were monitoring residents for COVID-19 through screening questions but only documenting in the clinical record if the resident had positive signs/symptoms of an infection. The temperatures were recorded on the MAR's for each resident. According to an email from the Nursing Home Administrator (NHA) on 4/1/2020, the facility began screening residents on 3/6/2020. Resident #4 According to the Admission Record, printed on 4/2/2020, Resident #4 had been admitted to the facility on [DATE]. The Order Summary, printed on 4/2/2020, revealed no physician order for [REDACTED]. Resident #4 had no monitoring on the March 2020 MAR. The temperatures in the Vital Signs section of the EMAR were not recorded for 3/21/2020, 3/22/2020, 3/23/2020, 3/24/2020, 3/27/2020, 3/29/2020, 3/30/2020, or 3/31/2020. Resident #5 According to the Admission Record, printed on 4/2/2020, Resident #5 had been admitted to the facility on [DATE]. The Order Summary, printed on 4/2/2020, revealed no physician order for [REDACTED]. Resident #5 had spaces on the March 2020 MAR to record vital signs beginning on 3/18/2020, not 3/6/2020 as indicated by the email from the NHA on 4/1/2020. The vital signs were missing for 3/28 and 3/31/2020. Resident #6 According to the Admission Record, printed on 4/2/2020, Resident #6 had been admitted to the facility on [DATE]. Resident #6 had spaces on the March 2020 MAR to record vital signs beginning on 3/18/2020, not 3/6/2020 as indicated by the email from the NHA on 4/1/2020. The vital signs were missing for 3/31/2020. Resident #7 According to the Admission Record, printed on 4/2/2020, Resident #7 had been admitted to the facility on [DATE]. Resident #7 had spaces on the March 2020 MAR to record vital signs beginning on 3/18/2020, not 3/6/2020 as indicated by the email from the NHA on 4/1/2020. The vital signs were missing for 3/24, 3/28, and 3/31/2020. Resident #8 According to the Admission Record, printed on 4/2/2020, Resident #8 had been readmitted to the facility on [DATE]. Resident #8 had spaces on the March 2020 MAR to record vital signs. The vital signs were missing for 3/28 and 3/31/2020. Resident #10 According to the Admission Record, printed on 4/2/2020, Resident #10 had been readmitted to the facility on [DATE]. Resident #10 had spaces on the March 2020 MAR to record vital signs beginning on 3/18/2020, not 3/6/2020 as indicated by the email from the NHA on 4/1/2020. The vital signs were missing for 3/31/2020. Resident #11 According to the Admission Record, printed on 4/2/2020, Resident #11 had been admitted to the facility on [DATE]. Resident #11 had spaces on the March 2020 MAR to record vital signs beginning on 3/18/2020, not 3/6/2020 as indicated by the email from the NHA on 4/1/2020. The vital signs were missing for 3/20/2020. Resident #12 According to the Admission Record, printed on 4/2/2020, Resident #12 had been readmitted to the facility on [DATE]. Resident #12 had spaces on the March 2020 MAR to record vital signs beginning on 3/18/2020, not 3/6/2020 as indicated by the email from the NHA on 4/1/2020. The vital signs were missing for 3/29 and 3/31/2020. Resident #13 According to the Admission Record, printed on 4/2/2020, Resident #13 had been admitted to the facility on [DATE]. Resident #13 had spaces on the March 2020 MAR to record vital signs beginning on 3/18/2020, not 3/6/2020 as indicated by the email from the NHA on 4/1/2020. The vital signs were missing for 3/31/2020. Resident #14 According to the Admission Record, printed on 4/2/2020, Resident #14 had been admitted to the facility on [DATE]. Resident #14 had spaces on the March 2020 MAR to record vital signs. The vital signs were missing for 3/28 and 3/31/2020. During a tour of the facility, on 4/1/2020 beginning at 9:45 AM, the receptionist screened the surveyors entering the building by having us fill out a questionnaire about COVID-19 and checking our temperatures with an electronic thermometer. No staff were observed wearing facemasks, not even the receptionist. During a telephone interview on 4/1/2020 beginning at 3:20 PM, Certified Nursing Assistant (CNA) E stated that she had to go looking for gloves to use for resident care. They are never where they should be. When asked about facemasks, she stated that she would wear a facemask for a resident who was in isolation. CNA E stated that supplies were scarce and the NHA felt like people were stealing/hoarding so he keeps supplies in his office. During a telephone interview on 4/1/2020 beginning at 5:00 PM, LPN F stated that the facility was rationing personal protective equipment (PPE) through the NHA. Staff had not been able to use facemasks and had not been given facemasks and there were no N-95 respirators. During a telephone interview on 4/1/2020 beginning at 5:50 PM, CNA H stated that the facility was short on disposable briefs for residents, gloves, and Styrofoam cups for passing water for residents. She stated that the gloves they had been given to provide the resident care were thin and rubbery, they broke easily and she thought they were kitchen gloves. CNA F said that she had gone to nurses for supplies and had been told by the nurses that they don't know about supplies. CNA F stated that the vital sign machine did not work correctly, if it worked. CNA F said that she had to seek out the nurses to use their personal blood pressure cuffs and had used the thermometer at the front desk to check residents temperatures. During a telephone interview on 4/2/2020 beginning at 8:16 AM, CNA J stated that the supply of gloves was low, and she had to go to the nurses to find gloves. Some of the gloves she had been given to use for resident care were of poor quality and she had been told that the facility had accidentally ordered non-medical gloves and had put them out for staff to use. CNA J said that facemasks were no longer available. The vital sign machine was broken and there was only one in the building. The nurses brought their personal blood pressure cuffs and the staff used them. During a telephone interview on 4/2/2020 beginning at 5:00 PM, LPN M stated that the staff had been given non-medical gloves to use for resident care. LPN M stated that the gloves were locked up in an office and that she was told to ration gloves. LPN M said that the vitals machine was broken, that a note had been taped to the machine and it was set by an office door. LPN M said that the staff were not allowed to wear facemasks because it scares the residents and makes it look like we have [MEDICAL CONDITION] (COVID-19). RN D told me I was making a big deal. The facility management is acting like nothing here is different. During a telephone interview on 4/3/2020 at 1:50 PM, LPN I reported that there was no PPE available, including gowns and facemasks, not even in the cabinet at the center nurses station, for Resident # 3 who had been on contact isolation when she had worked last. She stated that there were barely any gloves. LPN I also stated that the staff had been given kitchen gloves to perform resident care. The vitals machine did not work and she put a note on it and left it by the manager's door. LPN I stated that she would have to search to find disinfectant wipes. LPN I stated that she heard corporate RN N say that we could not wear facemasks. During a telephone interview on 4/2/2020 beginning at 9:20 AM, the Infection Preventionist, RN D stated that the NHA had been handling the inventory of PPE, she was not aware of the inventory. RN D stated that they had both medical and non-medical grade gloves and there were plenty. We put so many out per shift and yes we have enough. I think if we become desperate we may use the non-medical grade gloves. During an interview with the NHA on 4/1/2020 beginning at 9:50 AM, he stated that the PPE is kept in his office. Indeed, PPE in boxes were observed in his office. The NHA stated that gloves are not kept in every resident room now. He stated that he supplied gloves on the nurses medication carts, locked in the treatment carts, and in the nurses station on center wing every morning when he arrived at the facility and again before he left. The NHA confirmed that he had a supply of both medical and non-medical gloves. The NHA stated that he did not supply facemasks for the staff because they had no active or presumptive cases of COVID-19. During a telephone interview with the NHA on 4/2/2020 beginning at 9:30 AM, he stated that the facility was following recommendations from the Centers for Disease Prevention and Control (CDC). The NHA stated that the facility had three binders in the building and a bulletin board near the scheduler's office where he posted updates every day. During a telephone interview with Infection Preventionist RN D on 4/1/2020 beginning at 1:00 PM, she stated that she was educating staff, talking to them daily with updates and when the processes change with COVID-19 and that she was posting information as she got it on the bulletin board. RN D said that daily conference calls with the corporate were occurring. During a telephone interview with RN D on 4/2/2020 beginning at 9:20 AM, said she reviews guidance from the CDC, the Centers for Medicare and Medicaid, and the Agency for Healthcare Administration daily. RN D stated that she posted information on the bulletin board for staff and they can read it if they choose. RN D said they also have three binders with information, one was kept at the front desk. RN D said that she was not having group inservices right now due to the COVID-19 guidance. RN D said that she had done initially written and verbal inservices with smaller groups on 3/5/2020. RN D said that she had not watched staff put on and take off the PPE when Resident #3 was placed in isolation because she was not in the building. She stated that Resident #3 was not in isolation when she came back to the building. RN D was asked who had made the decision to not allow staff to wear masks, she responded, that she had gotten the information from corporate RN N, she deferred to the NHA when pressed for an answer to the question was the decision not made at the facility level? RN N: was also asked if she was keeping a special list for respiratory infections, she stated that the information was on the computer and had to log back in. She did not answer that question. The education records were requested. The facility provided a sign in sheet for education provided on 3/5/2020 that covered Handwashing - COVID-19 with the objectives of the inservice listed as -signs posted on doors & in break room for Residents/families - family letters sent out 3-6-2020 - trending/Tracking of infections by infection nurse -PPE supplies & when you need them. The inservice sheet was signed by 52 employees. The list of employees provided on 4/1/2020 included 112 employees. The other inservices that were provided were: On 3/30/2020 for updates on COVID-19 and was signed by six staff members of the dietary department; On 3/30/2020 on the Call-in Procedure detailing the information the caller provided and signs and symptoms if they were calling in for an illness. The information was to be reported to the Infection

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) Preventionist who would follow up. This was signed by eight staff. On 3/30/2020 for Daily Updates Covid-19 with objectives listed as *Continue taking temp upon entering and leaving building. -No holes in temp log allowed *PPE availability. *Be diligent* - WASH HANDS frequently! *Surveys starting this week This was signed by seven nursing staff members. 3/31/2020 titled Update - Covid 19. The objectives were 1. Continue to take temp when leaving facility. 2. New PPE posters are on the board 3. We have Ipads for resident's use. 4. Maintain Social Distancing This was signed by nine nursing staff members. Also attached was a communication from the corporate office, photos with explanations for putting on and removing PPE and seven pages of instructions for terminal cleaning a room of a COVID-19 resident with a reference page and a quiz with three questions signed, not dated, by six housekeeping staff. During a telephone interview on 4/1/2020 beginning at 3:20 PM, Certified Nursing Assistant (CNA) E stated that she did not receive any specific training, although she had attended a little inservice on handwashing. During a telephone interview on 4/1/2020 beginning at 5:00 PM, LPN F stated that they had an inservice on screening staff and residents for signs and symptoms associated with COVID. During a telephone interview on 4/1/2020 beginning at 5:50 PM, CNA H stated that there was no extra training. CNA H stated that the facility should prepare for COVID-19. During a telephone interview on 4/2/2020 beginning at 8:16 AM, CNA J stated that she had been pulled to work during her orientation. Now, she was just given handouts, there was no formal training. During a telephone interview on 4/2/2020 beginning at 5:00 PM, LPN M. When LPN M was asked about COVID training, she stated that the scheduler, a CNA, came around and asked if she knew how to wash her hands. He did not have a handout or watch her wash her hands. CNA G, CNA R, LPN Q, and LPN S were contacted by telephone on 4/1/2020 and left messages, but did not return the call for an interview. The scheduler, CNA K had called in and was not at work on 4/2/2020.