DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	474020	A. BUILDING ______ B. WING ______	**1/14/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDILODGE OF HOWELL	**1333 W GRAND RIVER HOWELL, MI 48843**

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E0000 SS=	Initial Comments Medilodge of Howell was surveyed for a COVID-19 Focused Infection Control Survey on 1/13/21 and is in compliance with 42 CFR Part 483.73(b)(6), Requirements for Long Term Care Facilities. Census = 175	E0000		
F0000 SS=	INITIAL COMMENTS Medilodge of Howell was surveyed on 1/14/21 for a Focused Infection Control and Prevention survey as well as an abbreviated survey. Intake #'s: 113313, 113353, 113554, 113375, 113930, 114090, 114399, 114727, 114913, 114949, 114950, 115445, 115451, 115965, 116006, 116087, 116143, 116354, 116528, 116583, 116607, 116716, and 116812 Census: 175 Census: 175	F0000		
F0677 SS= E	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: This citation pertains to intake #'s 115444, 115965, 114913, 114090. Based on observation, interview and record review the facility failed to ensure scheduled	F0677		

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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bathing was provided for six residents (R#'s 901, 902, 910, 912, 917, and 918) of seven residents reviewed for activities of daily living, resulting in the potential for poor personal hygiene. Findings include:

A review of multiple complaints reported to the State Agency included allegations that residents were not getting their scheduled showers.

R901

A review of R901's clinical record was conducted and revealed an admission date of 9/2/20 with diagnoses that included: diabetes, atrial fibrillation, Alzheimer's disease, and falls. R901's most recent Minimum Data Set (MDS) assessment dated 12/8/20 indicated R901 had severe cognitive impairment and required only supervision with most activities of daily living including ambulation. R901's MDS coding for bathing was document as "8", which indicated the activity did not occur during the 7-day look back period. A review of R901's physician's orders included an order dated that indicated R901 was to receive a shower twice a week. A request for all shower documentation from R901's admission on 9/2/20 to December 2020 was made. A review of the facility provided documents titled, "BATHTIME SKIN ANATOMY DIAGRAM" and the electronic CNA (Certified Nursing Assistant) task documentation for evidence of showers was conducted and revealed R901 received two

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showers in September, no evidence for showers was provided for October, and they refused one shower and received one shower on 11/27/20. R901's next documented shower wasn't until 12/16/20, 19 days later; and the next shower R901 received was on 12/26/20, 10 days later.

R902

A review of R902's clinical record was conducted and revealed an admission date of 10/1/20 with diagnoses that included: dementia with behaviors and bipolar disorder. R902's most recent MDS assessment dated 10/8/20 indicated R902 had severe cognitive impairment and was independently ambulatory. R902's MDS coding for bathing was documented as "8", which indicated the activity did not occur during the 7-day look back period. A review of R902's physician's orders included an order that indicated they were to receive a shower twice a week. A request for all shower documentation from 10/1/20 to December 2020 was made. A review of the facility provided documents titled, "BATHTIME SKIN ANATOMY DIAGRAM" and the CNA task documentation for evidence of showers was conducted and revealed that R902 received one shower for the month of October, one shower for the month of November, and two showers for the month of December.

R910

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On 1/5/2021 the medical record for R910 was reviewed and revealed the following: R910 was admitted to the facility on 2/6/2019 and had diagnoses including Alzheimer's disease, Muscle weakness and Chronic kidney disease. A review of R910's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/10/2020 revealed R910 needed assistance from staff with personal hygiene and bathing. R910 was documented as having severely impaired cognition.

A review of R910's care plan revealed the following: "Focus-ADL (activities of daily living); Dependent on others to appropriately identify and complete ADL needs in a safe and effective manner d/t (do to) cogn (cognitive) deficits, and weakness...Interventions-Dependent for drsg (dressing), hygiene, bathing, grooming..."

A review of R910's facility provided bathing documentation for November and December 2020 revealed R#910 had no record of being bathed in December and had one occurrence of being bathed in November on 11/7....No further bathing documentation of November or December 2020 for R#910 was received by the end of the survey.

R912

On 1/6/21 at 9:30 AM, an interview with R912 was conducted regarding whether they were getting their showers. R912 said they do not get their regularly scheduled showers on

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Sundays and Thursdays and cited the facility's staffing for the reason they were not getting them. R912 said that usually there are 2 CNA's assigned to the unit, but when one goes on break, that only leaves one CNA and said they require 2 person assistance for showering.

A review of R912's clinical record was conducted and revealed an admission date of 8/21/20 with diagnoses that included: quadriplegia, adjustment disorder, neurogenic bowel, and neuromuscular dysfunction of the bladder. A review of R912's MDS assessment dated 11/25 20 indicated R912 was cognitively intact, was non-ambulatory and required total assistance of two staff members for transferring, bed mobility, and bathing. A request for all shower documentation from 9/1/20 to December 2020 was made. A review of the facility provided documents included a "BATHTIME SKIN ANATOMY DIAGRAM" that was undated, and CNA task list documentation that indicated the following: September 2020, no showers given, three bed baths documented as given, out of the nine scheduled shower days. October 2020, one bed bath and one shower given, out of the nine scheduled shower days. November 2020, one shower given, and eight bed baths given. December 2020, no showers documented as given and four bed baths documented as given, out of the nine scheduled shower days.

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R917

On 1/6/21 at 3:00 PM, an interview with R917 was conducted regarding whether they get their scheduled showers. R917 indicated they got their showers only if there were enough aides. R917 said, "If there are only two aides, it's a no-go." When asked if they preferred a shower to a bed bath, they indicated they did. R917 stated, "I would like to go down there (shower room) at least twice a week and have my hair washed."

A review of 917's clinical record was conducted and revealed an admission date of 11/4/14 with diagnoses that included: multiple sclerosis, morbid obesity, diabetes, and peripheral vascular disease. R917's MDS assessment dated 11/9/20 indicated R917 had intact cognition, was non-ambulatory, and required total assistance of two staff members for bathing. A request for all shower documentation from 8/1/20 to December 2020 was made. A review of the facility provided documents did not include any "BATHTIME SKIN ANATOMY DIAGRAM" forms. A review of the CNA task list documentation indicated the following: August 2020, two showers and two bed baths given out of the nine scheduled shower days. October 2020, three showers and two bed baths given out of the nine scheduled shower days. November 2020, one shower and five bed baths given, out of the nine scheduled shower days. December 2020, three showers and three bed baths given, out of the nine

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scheduled shower days.

R918

On 1/5/21 at approximately 1:17 PM, R918 was observed sitting in a wheelchair in the hallway. The resident was alert, but not able to answer most questions asked, including those pertaining to ADL care.

A review of the resident's clinical record documented the resident was admitted to the facility on 7/2/2020 with diagnoses that included anxiety disorder, history of falling and special development disorder. A review of the resident's MDS documented the resident had a BIMS score of 7/15 (cognitively impaired) and required extensive one to two person assist for most ADLs.

A review of the electronic record pertaining to showers documented the resident was to receive showers on Sunday and Thursdays. A 30 day electronic look-back documented "non-applicable" on four occasion from 12/14/20 -1/4/21. A request was made to provide any documentation that indicated the resident received showers for the months December 2020 and January 2021. Bathroom Skin Anatomy Diagram forms were provided and documented the resident only received showers on 12/1/20 and 12/8/20.

A review of a facility provided policy titled, "Activities of Daily Living (ADLs), revised 10/30/20 was conducted and read, "...3. A

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	resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming,			
F0689 SS= G	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: This citation pertains to Intakes #MI00116087, MI00116143, MI00114727 and has two deficient practice statements. DPS #1 Based on interview and record review the facility failed to ensure interventions, including monitoring were in place to prevent falls for one (R#907) of two residents reviewed for falls, resulting in R#907 sustaining multiple falls, a hospital stay and a fractured right femur. Findings include: A Facility Reported Incident was reported to the State Agency that indicated a family member accused the facility of neglecting R907's care following a transfer from the memory care unit (South) to an observation unit (Daisy) following a hospitalization and failure to communicate changes to R907's daughter. Review of the Hospital records (date of service 10/20/20) documented, in part, that R#907, "...Patient is alert and oriented x1....therefore details obtained from chart review. Patient	F0689		

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presenting from (Facility name) secondary to unwitnessed fall and subsequent right hip fracture. Attempted to contact (Facility name) for additional details without success. Per chart review patient reportedly had 3 falls yesterday with the last one occurring at approximately 2330...Right hip x-ray was completed and demonstrated fracture, so she was sent to emergency room for further treatment.... Per patients daughter patient has had multiple falls since returning to Medilodge on 10/14...".

A review of R#907's clinical record documented that the resident was initially admitted to the Facility on 1/10/20 with diagnoses that included: Alzheimer's, dementia, Type II diabetes, a readmission date of 10/27/20 documented the resident had a non-displaced fracture of the right femur. Review of R#907's Minimum Data Set (MDS) indicated that the resident was severely cognitively impaired and had a history of falls.

Continued review of the resident's record documented, in part, the following:

10/4/20: "Resident observed attempting to sit on a chair and landing on her bottom on the floor...".

10/8/20: "Resident was hypertensive...departed on route to (name redacted) hospital...".

10/14/20: "Resident arrived to facility via EMS (emergency medical services) ...attempting to enter other resident's rooms...will continue to monitor...". It should be noted R#907 was admitted to the Daisy unit on 10/14/20.

10/15/20 (8:17 PM) (authored by Nurse "S"): "Resident observed laying on floor of hallway near double doors...No injuries noted...".

10/15/20 (8:22 PM)"...Date of fall

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10/15/20...Interventions: BLANK...".

10/19/20 (6:30 PM) (authored by Nurse "S")"...Resident observed falling on floor at the end of hall near exit door. Assisted resident to bed....".

10/19/20 (7:00 PM)"...Date of fall: 10/19/20...Interventions: BLANK...".

10/19/20 (8:08 PM) (authored by Nurse "S") "...Resident observed falling to floor after attempting to push CNA...Resident was complaining of some pain in right hip...physician stated to monitor resident for continued hip pain. If pain continue, physician stated to order x-ray.
10/19/20 (8:15 PM)"...Date of Fall: 10/19/20...Resident observed falling to floor after attempting to push CNA way...Resident stated her right hip was sore after she landed on it...Interventions: BLANK...".

10/20/20 (2:07 AM) "Observed resident on her knees next to her bed...C/O (complained of) right hip and needed 2A (two person assist to stand) ...Interventions: Low bed....".

10/20/20 (3:00 AM): "Had 3 falls today...".

Further review of R#907's record documented:

Pertinent Charting Initial- Falls: "Date 10/18/2020...Date of Fall...2. Is this a new event YES...Nurse came out of a patient room and observed the patient falling in the hallway.... patient did not hit her head...Injury ...No new interventions, trying to anticipate needs as much as possible...". Nursing notes pertaining to this fall were not noted.

The Fall Risk Assessment dated 1/20/20 indicated a Fall Risk score of 10.0 the Assessment

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increased to 15.0 following the fall noted 10/4/20 (above) and increased to 20.0 following fall noted 10/19/20.

A request was for R#907's Incident and Accident (I/A) reports was made. A review of the I/A reports provided during the residents stay on the Daisy unit documented, in part the following:

10/15/20: "R#907...time of incident (8:00 PM) ...Memory impaired...Decision making impaired...Was incident witnessed (NO)...Resident observed laying on floor at end of hallway next to hoyer lift...Results of Investigation: Continue current plan...".

10/19/20: "R#907...time of incident: (11:52 PM) ...Resident Memory impaired...Decision making impaired...physically impaired...Was incident witnessed (NO).... CNA was doing round observed resident ...next to bed...C/O right hip pain...3rd fall in 24...no redness or injury noted...Results of Investigation: Will review on return for needs...".

*It should be noted that R#907's progress notes/ indicated that the resident had a fall on 10/18/20 and three falls (two on 10/19/20 and one on 10/20/20) as shown above only one I/A for the 10/19/20 fall was provided prior to the end of the survey.

A review of the R#907's care plan documented the following: "At risk for falls d/t dx DM, potential med, ...and cognitive deficits resulting in difficulty identifying safety risks and making safe choices (Date Initiated 1/21/2020- Revision on 1/21/20...Interventions: Anticipate and meet the resident's needs based on nursing assessments (date initiated 1/21/20), Determine causative factors of fall and resolve or minimize (date initiated 1/21/20), Encourage resident to wear

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non-skid socks or non-skid shoes; note resident prefers to walk in bare feet and will become agitated with staff attempts to apply footwear (date initiated 7/9/20), Encourage rest periods as needed to avoid overtiring (date initiated 1/21/20), Monitor tiredness after dinner (date initiated 10/4/20), Physical ...therapy to evaluate and treat as ordered or as needed (date initiated 1/21/20), Provide for activities of daily living... (date initiated 1/21/20), Refer to Physical Therapy/Occupational Therapy as indicated (date initiated 1/21/20), Remind the resident to do the following (walk slowly through crowded resident areas). Assist resident to toilet after all meals (7/7/20). It should be noted that the last intervention initiated into the resident's care plan was 10/4/20.

Hospital record (date of service 10/8/20-10/13/20) documented, in part, the following: "Patient was transferred to (Facility name) on 10/8/20 for hypoxic respiratory failure as well as obstruction of left...stone.... Family has requested to speak with social work/case manager regarding logistics of patients discharge. Unfortunately, per protocol, it seems with every medical visit patient will require up to 14 days quarantine at her facility which will be further detrimental to her mental state and orientation."

On 1/12/21 at approximately 12:30 PM a phone interview was conducted with Nurse "S". Nurse "S "was queried as to R#907's care pertaining to her falls while on the Daisy unit. Nurse "S" indicated that she no longer was employed by the Facility but recalled the resident and noted that resident had formerly resided on the South memory hall and following hospitalization she was transferred to the Daisy unit. Nurse "S" reported that it was difficult to provide continuous care to the resident as the facility was very short staffed and often there was only one CNA on the unit to assist with care. When

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queried as to why interventions/I/A's were not completed for the falls occurring on the Daisy unit, Nurse "S" again reported that due to the lack of staff, it was difficult to complete the I/As and other documentation.

On 1/13/21 at approximately 10:00 AM, an interview was conducted with the Assistant Administrator pertaining to R#907. When queried as to the Facility's policy regarding falls and fall intervention, she indicated that I/As should be completed after each falls and interventions should be put into the resident's care plan to prevent future falls.

The Facility's Policy titled "Fall Prevention Program" (Date revised 10/20/20) was reviewed and documented in part, the following: "Policy: Each resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls.5. Each resident's risk factors, and environmental hazards will be evaluated when developing the residents comprehensive plan of care. Interventions will be monitored for effectiveness...the plan of care will be revised as needed....6. When any resident experiences a fall, the facility will...c. complete an incident report...obtain witness statements in the case of injury...".and personal and oral hygiene..."

Deficient practice #2

Based on observation, interview and record review the facility failed to ensure safe operation of resident equipment for one resident (R#906) of three residents reviewed for accidents/hazards, resulting in the potential for injury to occur. Findings include:

On 1/7/2021 at approximately 2:53 p.m.,

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R#906 was observed in the common area sitting in a Broda chair (tilt-in-space positioning chair) with R#906's feet resting in the footrest.

On 1/5/2021 the medical record for R#906 was reviewed and revealed the following: R#906 was initially admitted to the facility on 7/22/2016 and had diagnoses including Dementia, Muscle weakness and History of falling. A review of R#906's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/22/20 revealed R#906 needed extensive assistance from facility staff with most of their activities of daily living. R#906's cognition was documented as severely impaired.

A nurses skin note dated 12/24/2020 revealed the following: " Location of skin area being documented: Right foot. Description: Large purple / red bruising to right great toe and across the top of foot. Interventions: Switched out [R#906] broad chair for one with footrest so that her feet are up off the floor. Comments: Another resident had been observed earlier pushing on [R#906] chair towards the table, when CNA (certified nursing assistant) was fixing [R#906] sock a bruise was observed on her right foot."

An incident report dated 12/24/2020 was reviewed and revealed the following: "Date of Incident: 12/24/2020...Brief description: Writer had noted another resident push [R#906]'s chair towards table, CNA was fixing

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[R#906]'s sock and bruise (red/purple) was resent to top of R (right) food from great toe across the top of foot...Injury type: Hematoma/Bruise...Equipment: Broda with no footrest...Action taken: New chair with footrest.

An investigation report dated 12/24/20 revealed the following: "Results of investigation: Resident feet with new bruisings near toes, new Broda chair provided to protect feet..."

On 1/7/21 at approximately 2:37 p.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding R#906's incident on 12/24/20. The DON indicated that R#906's footrest was missing from their chair. The DON was queried if R#906 should have had the footrest on their chair prior to being moved and they indicated that they should have. The DON indicated that they were aware of the bruise on the foot when it was found and that they had to get a new chair for R#906 with a footrest on it to protect their feet. The DON was queried regarding the incident report that indicated R#906 had been pushed in the chair by another resident on the unit and the DON indicated that R#906's unit has a lot of cognitively impaired residents. The DON was queried if other residents could be pushing R#906 and they indicated that they shouldn't. The DON was queried if they had been aware of R#906 not having the footrest attached to their chair and they indicated that they

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	weren't until the incident of the bruise occurred. On 1/12/21 at approximately 2:53 p.m., Nurse "A" was queried regarding R#906's bruise on 12/24/20. Nurse "A" indicated that one of the aides had notified them that R#906 had a bruise on their foot. Nurse "A" further reported that they had been informed that another resident on the unit had been observed pushing R#906 in their Broda chair. Nurse "A" was queried if R#906 had the footrest on the chair to protect their feet and they indicated that they didn't. Nurse "A" was queried if R#906 should have had the footrest attached to the chair to protect their feet and they indicated that they should have. Nurse "A" reported that it was difficult to get equipment. Nurse "A" indicated that the DON had to be notified so a new chair could be found for R#906. Nurse "A" was queried regarding supervision on the unit and why another resident was pushing R#906 and they indicated that R#906's unit has many residents that have behaviors and that due to their short staffing they can't always watch them. Nurse "A" was queried if R#906's foot bruise could potentially have been avoided if R#906 had their footrest attached to their chair and staff had intervened when R#906 was observed being pushed by another resident and they indicated that it could have. A facility document titled "Accidents and Supervision" (10/30/2020) was reviewed and			

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	revealed the following: "The resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. This includes l. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3.Implementing interventions to reduce hazard(s) and risk(s). 4.Monitoring for effectiveness and modifying interventions when necessity..."			
F0725 SS= F	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F0725		

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This citation pertains to intake #'s MI00116087, MI00115965, MI00115445, MI00114913 and MI00114090.

Based on observation, interview and record review, the facility failed to provide adequate staffing to meet resident needs, for seven residents (R#'s 901, 902, 908, 909, 910, 912, and 917) of seven residents reviewed for staffing, resulting in complaints of short staffing, staff not being able to provide all aspects of care including bathing, monitoring, and timely assistance with eating meals. This has the potential to affect all 175 residents that reside within the facility. Findings include:

A review of multiple complaints reported to the State Agency included allegations that there was not enough staff to consistently provide activities of daily living (ADL's) including bathing to the residents in the facility.

R908

On 1/5/21 the medical record for R908 was reviewed and revealed R908 was admitted to the facility on 2/21/20 with diagnoses that included dementia and epilepsy. A review of R908's physician's orders included an order for increased monitoring for signs and symptoms of respiratory illness and to document a progress note and contact the

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physician. An order administration note by former employee, Nurse 'S' dated 10/31/20 in response to the order was reviewed and read, "...unable to obtain due to short staff..." A review of additional responses to the order were reviewed and revealed that on 11/2/20, 11/5/20, 11/6/20, and 11/9/20 the following was documented: "...Unable to complete due to staffing..." A physician order administration note by the licensed nurse dated 11/1/20 for obtaining vital signs per Center for Disease Control was reviewed and read, "...Unable to complete due to staffing..."

R909

On 1/5/21 the medical record for R909 was reviewed and revealed the following R909 was admitted to the facility on 7/14/20 with diagnoses that included dementia and unspecified intellectual disabilities.

A review of R909's physician's orders included an order for increased monitoring for signs and symptoms of respiratory illness and to document a progress note and contact the physician. An order administration note by the licensed nurses dated 10/22/20 and 10/23/20 in response to the order was reviewed and read, "...Unable to complete due to staffing..."

R910

On 1/5/21 the medical record for R910 was reviewed and revealed R910 was admitted to

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the facility on 2/6/19 with diagnoses that included: Alzheimer's disease and chronic kidney disease. R910's MDS assessment dated 11/10/20 indicated they had severely impaired cognition and required assistance from staff for personal hygiene and bathing.

A review of R910's physician's orders included an order for increased monitoring for signs and symptoms of respiratory illness and to document a progress note and contact the physician. An order administration note by the licensed nurses dated 11/2/20, 11/5/20, and 11/6/20, in response to the order was reviewed and read, "...Unable to complete due to staffing..." Additional physician order administration notes for obtaining the vital signs for monitoring for COVID-19 were reviewed and documented the following, "...Unable to complete due to staffing..." by the licensed nurses on 10/31/20 and 11/1/20.

A review of R910's facility provided bathing documentation for September, October, November and December 2020 revealed R#910 had no record of being bathed in December and had one occurrence of being bathed in November on 11/7. No further bathing documentation for November or December 2020 for R#910 was received by the end of the survey.

A review of R910's care plan revealed the following: "Focus-ADL (activities of daily living); Dependent on others to appropriately

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identify and complete ADL needs in a safe and effective manner d/t (due to) cogn (cognitive) deficits, and weakness...Interventions-Dependent for drsg (dressing), hygiene, bathing, grooming..."

An interview with former Nurse 'S' was conducted on 1/12/21 at approximately 10:23 AM. Former Nurse "S" who had documented they were unable to complete their assessments due to staffing was queried about their responses and indicated that they did not have enough staff working on their units to be able to complete the assessments. Nurse "S" indicated that all they could do was pass medications and they were not able to assist the aides on the unit with care. Nurse "S" further indicated that they had to stop working at the facility because they felt their license was at risk to the inadequate level of staffing on the unit. Nurse "S" was queried how the lack of staffing affected the staff's ability to provide resident care and Nurse "S" indicated that showers weren't able to be completed.

On 1/6/21 at 10:30 AM, an interview with CNA 'C' was conducted regarding facility staffing. CNA 'C' said they were the only CNA assigned to the Daisy unit, the 14 day observation unit. CNA 'C' said they needed more help, and they were frequently going to the Rose Unit (The unit that had COVID-19 positive residents) to help out over there. It was noted that CNA 'C' tested positive for COVID-19 on 1/8/21.

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On 1/6/21 at approximately 11:10 AM, an interview with Registered Nurse (RN) 'G' was conducted on the Rose Unit. RN 'G' was asked about staffing and said she was the only nurse on the unit and there was no assigned CNA, CNA 'C' was coming over to the unit from the Daisy unit.

R901

A review of R901's clinical record was conducted and revealed an admission date of 9/2/20 with diagnoses that included: diabetes, atrial fibrillation, Alzheimer's disease, and falls. R901's most recent Minimum Data Set (MDS) assessment dated 12/8/20 indicated R901 had severe cognitive impairment and required only supervision with most activities of daily living including ambulation. R901's MDS coding for bathing was document as "8", which indicated the activity did not occur. A review of R901's physician's orders included an order dated that indicated R901 was to receive a shower twice a week. A request for all shower documentation from R901's admission on 9/2/20 to December 2020 was made. A review of the facility provided documents titled, "BATHTIME SKIN ANATOMY DIAGRAM" and the electronic CNA (Certified Nursing Assistant) task documentation for evidence of showers was conducted and revealed R901 received two showers in September, no evidence for showers was provided for October, and they refused one

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shower and received one shower on 11/27/20. R901's next documented shower wasn't until 12/16/20, 19 days later; and the next shower R901 received was on 12/26/20, 10 days later.

R902

A review of R902's clinical record was conducted and revealed an admission date of 10/1/20 with diagnoses that included: dementia with behaviors and bipolar disorder. R902's most recent MDS assessment dated 10/8/20 indicated R902 had severe cognitive impairment and was independently ambulatory. R902's MDS coding for bathing was documented as "8", which indicated the activity did not occur. A review of R902's physician's orders included an order that indicated they were to receive a shower twice a week. A request for all shower documentation from 10/1/20 to December 2020 was made. A review of the facility provided documents titled, "BATHTIME SKIN ANATOMY DIAGRAM" and the CNA task documentation for evidence of showers was conducted and revealed that R902 received one shower for the month of October, one shower for the month of November, and two showers for the month of December.

R912

On 1/6/21 at 9:30 AM, an interview with R912 was conducted regarding whether they were getting their showers. R912 said they don't

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	get their regularly scheduled showers on Sundays and Thursdays and cited the facility's staffing for the reason they were not getting them. R912 said that usually there are 2 CNA's assigned to the unit, but when one goes on break, that only leaves one CNA and said they require 2 person assistance for showering. A review of R912's clinical record was conducted and revealed an admission date of 8/21/20 with diagnoses that included: quadriplegia, adjustment disorder, neurogenic bowel, and neuromuscular dysfunction of the bladder. A review of R912's MDS assessment dated 11/25 20 indicated R912 was cognitively intact, was non-ambulatory and required total assistance of two staff members for transferring, bed mobility, and bathing. A request for all shower documentation from 9/1/20 to December 2020 was made. A review of the facility provided documents included a "BATHTIME SKIN ANATOMY DIAGRAM" that was undated, and CNA task list documentation that indicated the following: September 2020, no showers given, three bed baths documented as given, out of the nine scheduled shower days. October 2020, one bed bath and one shower given, out of the nine scheduled shower days. November 2020, one shower given, and eight bed baths given. December 2020, no showers documented as given and four bed baths documented as given, out of the nine scheduled shower days.			

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R917

On 1/6/21 at 3:00 PM, an interview with R917 was conducted regarding whether they get their scheduled showers. R917 indicated they got their showers only if there were enough aides. R917 said, "If there are only two aides, it's a no-go." When further asked about staffing, R917 indicated that it had been an on-going problem and they had been expressing their frustrations to Administration since at least November. R917 further stated, "Last week, I didn't get touched until the second shift. I'm worried about the residents that can't speak for themselves."

A review of 917's clinical record was conducted and revealed an admission date of 11/4/14 with diagnoses that included: multiple sclerosis, morbid obesity, diabetes, and peripheral vascular disease. R917's MDS assessment dated 11/9/20 indicated R917 had intact cognition, was non-ambulatory, and required total assistance of two staff members for bathing. A request for all shower documentation from 8/1/20 to December 2020 was made. A review of the facility provided documents did not include any "BATHTIME SKIN ANATOMY DIAGRAM" forms. A review of the CNA task list documentation indicated the following: August 2020, two showers and two bed baths given out of the nine scheduled shower days. October 2020, three showers and two bed

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baths given out of the nine scheduled shower days. November 2020, one shower and five bed baths given, out of the nine scheduled shower days. December 2020, three showers and three bed baths given, out of the nine scheduled shower days.

On 1/7/21 at approximately 10:35 AM, a review of facility provided Resident Council meeting minutes was conducted and indicated that on 11/13/20 residents in attendance had expressed concerns about the facility's staffing numbers. The minutes read, "...Residents asked about staffing-staffing based on census and accity <sic>..." The meeting minutes did not provide any additional information regarding the facility's response to the resident's concerns.

On 1/12/21 at 10:55 AM, a phone conversation with an anonymous complainant was conducted. The complainant explained their concerns about staffing and said their loved one had recently been diagnosed with COVID-19 and was so afraid of not enough staff to monitor them they wanted to be transferred to the emergency room.

On 1/12/21 at approximately 11:00 AM an interview was conducted with Nurse "U" regarding staffing. Nurse "U" reported that staffing had severely declined over the past few months causing difficulty completing resident care, including showers.

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On 1/12/21 at approximately 2:01 p.m., CNA (certified nursing assistant) 'T' as queried regarding the staffing level in the building. CNA "T" indicated that they had 26 residents to care for and reported that staffing was not adequate that day and they were not able to complete all the showers that were scheduled to be done during their shift.

On 1/13/21 at approximately 11:00 a.m., Staffing scheduler "N" was queried regarding the staffing levels in the building. Scheduler "N" indicated the staffing level in the facility is inadequate and that the residents are not getting their care they need. Scheduler 'N' explained they had been working the floor as a CNA and the DON had been making the assignments. Scheduler "N" was queried regarding the facility provided CNA assignment sheet for 1/12/2021 that showed only 6.5 CNA's were assigned to work and the total amount required was 20. Scheduler "N" indicated that they were short "about 7-8 aides." Scheduler 'N' further explained they stayed over on 1/12/21 because if they didn't, the CNA would have had 67 or 68 patients. Scheduler 'N' stated, "Not that I have to stay, but the residents aren't getting the care." When asked about what type of care was not being provided related to staffing, Scheduler 'N' explained that showers weren't getting done and residents were probably getting cold food because of the amount of residents on certain units that required assistance with eating.

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	On 1/13/21 at approximately 11:00 AM an interview with the facility's Administrator, Assistant Administrator, and Director of Nursing (DON) was conducted. At that time, the DON said that because of staffing he had been filling in on the floor and he was also trying to handle the recent COVID-19 outbreak. He also indicated that unit managers were also filling in for assignments on the floor. The Administrator indicated they were aware of a staffing problem in the building. When asked if part of their plan to address staffing was to not accept any new admissions, they indicated they were still taking new admissions. A Policy titled "Nursing Services and Sufficient Staff" (Date revised 10/30/20) was reviewed on 1/14/21 and documented, in part, the following: "Policy: It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well being of each resident. .... The facility will supply services by sufficient numbers .... on a 24 hour basis to provide nursing care to all residents in accordance with resident care plans...".			
F0812 SS= F	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local	F0812		

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authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:

This citation pertains to intake #MI00114913.

Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen and ensure kitchen cleaning duties were being performed resulting in dirty and soiled kitchen equipment and the increased potential for foodborne illnesses. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include:

A review of multiple complaints reported to the State Agency included allegations that there were unsanitary conditions in the kitchen.

On 1/5/21 from 9:45 AM until approximately 10:20 AM, a tour of the facility's kitchen was conducted. It was noted the only appliances in use at that time were the double convection oven and the large cooking steamer. Staff were observed in the kitchen going about their duties, the following observations were made:

A stainless-steel table (adjacent to the double

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convection oven) with a bottom shelf containing large stock pots and cutting boards was observed to have crumbs and debris on the tabletop and bottom shelf. A layer of what appeared to be greasy build-up was also observed on the bottom shelf.

The six burner gas stove backsplash was soiled with blackened, dried on, splatter debris. The vent hood above the gas stove was observed to have dusty cobwebs attached. Next to the stove was a tilt skillet (a piece of commercial cooking equipment that is used to prepare a variety of foods in large batches. Behind the tilt skillet, a spatula was observed on the kitchen floor.

A square stainless-steel cart was observed in the corner of the kitchen (near the natural gas shut off valve) was observed to have soiled and rusty legs and wheels.

A stainless-steel table across from the tilt skillet was observed to have crumbs and food debris on the bottom shelf.

In front of the ice machine, a reddish/pink substance was observed to be dried onto the floor tile and in the tile grout.

The steam table near the center of the kitchen was observed and was not in use at the time of the observation. The rubber bumper around the bottom edge and caster wheels was observed to be soiled with dried on spilled food stains. The steam table lids were observed to have food crumbs and debris on the tops. Underneath the steam table a bright reddish/pink substance was dried on the floor as well as other splatter stains and food and paper debris.

Behind the steam table was a stainless-steel table with an industrial coffeemaker on top. Behind the

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table (in between the in-floor power source and the table) litter such as napkins, plastic utensils, cup lids, and various other paper waste was observed. The top of the coffeemaker was soiled with dried on black stains, and coffee grounds were accumulated on the back of the coffeemaker near where the coffee grounds would be placed in the machine for making coffee.

Adjacent to the table with the coffeemaker was a juice machine. The juice machine appeared to have a leak, and an orange liquid was observed on the floor under the machine tubing. An observation of the filter on the juice machine revealed thick, caked on dust and debris.

On 1/5/21 at 10:30 AM a second tour of the kitchen was conducted with the facility's Dietary Director. The director was asked about the stainless-steel tabletops and bottom shelves. They indicated the tables and shelves should have been wiped down and should not have had the greasy appearing buildup on them. During the observation, the double oven was noted to have the shadow of a greasy shoe print on the bottom oven door. The Director had no explanation for the shoe print but would be addressing it with staff. At that time, the Director was asked about the black stains on the back of the 6-burner stove and indicated the stove and the backsplash could have been cleaner. When asked about the cobwebs in the vent hood, the Director explained that a company usually is contracted for the cleaning but since they were new to the facility as the Dietary Director, they were unsure of the last time they had been cleaned. The Director was asked to show the inside of the tilt skillet and when opened, approximately 3 cups of previously cooked, dried up elbow macaroni was observed. When asked the last time a meal was served that contained elbow macaroni, the Director indicated they did not know. The Director explained they were aware the kitchen needed some attention and

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things (appliances, tables, ice machine, etc.) needed to be moved around to thoroughly clean the kitchen.

The Dietary Director was asked who was responsible to ensure the kitchen was maintained in a clean and sanitary manner and indicated it was all kitchen staff's responsibility. At that time, schedules that pertained to cleaning the kitchen were requested, as well as any service invoices for the vent hood and juice machine.

On 1/5/21 at approximately 1:30 PM, a review of facility provided kitchen cleaning schedules and check off logs was conducted. The schedules had each of the kitchen staff positions by shift (AM and PM) with lists of several different cleaning duties for each staff position. For the week of 11/30/20-12/6/20 it was noted that the "Chef AM" cleaning duties were not signed off as scheduled (Monday thru Friday) for the entire week. The "Pots AM" cleaning duties were not signed off as being completed on 11/30 and 12/1. The "Dietary Aide Tray checker/Loader AM" duties were not signed off as being completed on 11/30, 12/2, 12/3/12/4, 12/5, and 12/6. The "Dietary Aide run caddies AM" duties were not signed off as being completed on 12/1, 12/4/, 12/5, and 12/6. The "Dietary Aide Cards AM" duties were not signed off as being completed on 11/30, 12/1, 12/5, and 12/6. The "Beverage Prep AM ..." duties were not signed off as being completed for the entire week of 11/30-12/6. The "Dish Line Clean AM" duties were not signed off as being completed on 11/30, 12/2, 12/3, 12/4, 12/5, or 12/6. The "Dish Line Middle AM" duties were not signed off as being completed on 11/30, 12/1, 12/2, 12/5, and 12/6. The "Dish Line Dirty AM" duties were not signed off as being completed on 11/30, 12/2, 12/4, 12/5 and 12/6.

A review of the cleaning schedules for the week

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	of 12/7/20-12/13/20 was conducted and it was noted the "Chef AM" cleaning duties were not signed off as being completed at all during the week. The "Dietary Aide Tray checker/Loader AM" duties were not signed off as being completed on 12/7, 12/8, 12/10, 12/11, 12/12, or 12/13. The "Dietary Aide run caddies AM" duties were not signed off as being completed on 12/7 and 12/10. The "Dietary Aide Cards AM" duties were not signed off as being completed on 12/7 and 12/10. The "Beverage Prep AM ..." duties were not signed off as being completed on 12/7, 12/12, and 2/13. The "Dish Line Clean AM" duties were not signed off as being completed on 12/7, 12/8, 12/10, and 12/11. The "Dish Line Middle AM" duties were not signed off as being completed on 12/7, 12/10, and 12/13. The "Dish Line Dirty AM" duties were not signed off as being completed on 12/8, 12/10, 12/12, and 12/13. A review of the cleaning schedules for 12/14/20-12/20/20 was conducted and it was noted "Chef AM" cleaning duties were not signed off as being completed at all during the week. The "Dietary Aide Tray checker/Loader AM" duties were not signed off as being completed on 12/14, 12/15, 12/17, 12/18, 12/19, and 12/20. The "Dietary Aide run caddies AM" duties were not signed off as being completed on 12/14, 12/15, 12/17, 12/18, and 12/20. The "Dietary Aide Cards AM" duties were not signed off as being completed at all during the week. The "Beverage Prep AM ..." duties were not signed off as being completed on 12/14, 12/18, and 12/19. The "Dish Line Clean AM" duties were not signed off as being completed on 12/14, 12/15, 12/16, 12/19, and 12/20. The "Dish Line Middle AM" duties were not signed off as being completed on 12/14, 12/15, 12/17, 12/18, 12/19, and 12/20. The "Dish Line Dirty AM" duties were not signed off as being completed at all during the week. The "Dietary Aide Run Caddies PM" duties were not			

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signed off as being completed on 12/17, 12/18, and 12/19. The "Dish Line Clean PM" duties were not signed off as being completed on 12/15, 12/16, 12/17, and 12/18. The "Dish Line Dirty PM" duties were not signed off as being completed on 12/14, 12/19, and 12/20.

A review of the cleaning schedules for the week of 12/21/20-12/27/20 was conducted and it was noted "Chef AM" cleaning duties were not signed off as being completed at all during the week. The "Dietary Aide Tray checker/Loader AM" duties were not signed off as being completed on 12/23, 12/24, 12/25, and 12/27. The "Dietary Aide run caddies AM" duties were not signed off as being completed on 12/21, 12/23, 12/24, 12/25, 12/26, and 12/27. The "Dietary Aide Cards AM" duties were not signed off as being completed on 2/21, 12/23, 12/24, 12/25, 12/26, and 12/27. The "Beverage Prep AM ..." duties were not signed off as being completed on 12/21 and 12/22. The "Dish Line Clean AM" duties were not signed off as being completed on 12/21, 12/23, 12/24, 12/25, 12/26, and 12/27. The "Dish Line Middle AM" duties were not signed off as being completed on 12/21, 12/23, 12/24, 12/25, 12/26, and 12/27. The "Dish Line Dirty AM" duties were not signed off as being completed on 12/21, 12/23, 12/24, 12/25, 12/26, and 12/27. The "Tray Checker/Loader PM" duties were not signed off as being completed on 12/21, 12/23, 12/24, and 12/26. The "Dietary Aide Run Caddies PM" duties were not signed off as being completed on 12/21, 12/23, 12/26, and 12/27. The "Dish Line Clean PM" duties were not signed off as being completed on 12/21, 12/23, 12/24, 12/26, and 12/27. The "Dish Line Dirty PM" duties were not signed off as being completed on 12/21, 12/23, and 12/24.

On 1/5/21 at approximately 2:00 PM, a review of two facility provided invoices from the juice machine vendor was conducted. The first invoice

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	dated 4/24/20 read, " ...DESCRIPTION OF WORK: 90 day clean & Sanitize ..." The second invoice dated 10/20/20 read, "WORK COMPLETED: Pulled old cart and installed new cart. Hooked up water and product. Pressurized and adjusted mix...Tested." On 1/5/21 at approximately 2:05 PM, a review of a facility provided work order created on the facility's electronic work order system was reviewed. The work order indicated that on 12/15/20 an order was requested that read, "hood filter need cleaned-dust and cobwebs". The "Timeline" for the work order indicated it was "Set to Closed" on 12/28/20. The work order did not indicate the work had been completed. Invoices for independent vendors contracted to clean the vent hoods were not provided by the end of the survey. A review of a facility provided policy titled, "Kitchen Sanitation" with a revision date of 7/31/20 was conducted and read, "Policy: The food service area shall be maintained in a clean and sanitary manner ..."			
F0880 SS= K	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F0880		

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	staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:			

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Based on observation, interview, and record review, the facility failed to follow the Center for Disease Control (CDC) protocol for COVID-19 including: encouraging social distancing and mask use for residents, and following current infection control principles/CDC protocol regarding the following: environmental cleaning, appropriate personal protective equipment (PPE) use, availability of sanitizing supplies, appropriate areas for doffing PPE used on the COVID-19 designated unit, ensure staff knowledge of isolation equipment (plastic partitions), isolate residents after exposure to COVID-19 (R#'s 927 and 928), ensure staff were educated on the facility's COVID-19 outbreak, proper placement of garbage cans in transmission based precaution rooms, increased respiratory monitoring for one COVID-19 positive resident (R912), and appropriate room assignments and cohorting (R#'s 925 and 926) resulting in Immediate jeopardy (IJ). This deficient practice caused the spread of COVID-19, the need to transfer residents to acute care settings, and the likelihood for serious harm, injury, and or death.

The IJ began on 1/6/21, it was identified by the survey team on 1/13/21 and the facility was notified on 1/13/21 at approximately 2:35 PM. On 1/14/2021, the facility Plan of Removal was accepted by the State Agency. A completed verification to ensure the Immediate Jeopardy was removed was conducted on 1/14/2021, however the facility remained out of compliance at a scope of "pattern" and severity of "potential for more than minimal harm that is not Immediate Jeopardy" due to sustained compliance that has not yet been verified by the State Agency.

On 1/5/21 at approximately 8:45 AM, the facility reported they had no positive resident COVID-19

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cases. It was reported the Daisy unit (Rooms 200-215) was their designated unit for re-admissions, new admissions, and other residents who may require a 14-day observation period for signs and symptoms of COVID-19.

On 1/5/21 at 5:54 PM, an e-mail from the facility's Director of Nursing (DON) was received. The e-mail indicated the facility had completed their scheduled COVID-19 testing and seven residents tested positive for COVID-19 after the completion of their testing.

On 1/6/2021 at approximately 9:00 AM, the Facility provided a list of seven residents, along with their room numbers, who were COVID-19 positive as of 1/5/21. Two of the residents resided in private rooms on the Daisy unit (the 14-day observation unit), and five resided on the Lily unit (Rooms 220-237), two resided in room 223, two in room 229 and one in room 227. The Facility informed the Surveyors that six out of seven residents were transferred to different rooms on the Rose unit (Rooms 240-257), and a COVID-19 unit was established.

On 1/6/21 at approximately 9:26 AM, the dining room in the facility's locked unit (were a significant number of cognitively impaired residents resided) was observed to have one table with three residents seated closer than six feet of each other without wearing any facial coverings. A second table in the dining room was observed to have three more residents seated within six feet from one another and without any facial coverings. Two tables in the dining room were observed to have no residents seated at them. No staff members were observed attempting to safely separate the residents; nor were any of the staff encouraging or attempting to encourage residents to wear facial coverings. A sign in the dining room was observed to indicate residents should

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be kept at least six feet away from one another.

On 1/6/21 at approximately 9:15 AM an observation on the Lily unit was conducted. There was no indication on the double doors entering into the unit regarding what, if any PPE (personal protective equipment) should be worn. The doors to room 223, 227, and 229 were slightly ajar. No residents resided in these rooms as the residents from those room that tested positive for COVID-19 were transferred to the Rose unit and/or hospital. Housekeeper "I" was observed entering into room 227 wearing a surgical mask, eye protection and gloves. Upon entry the door was left open and several items, including PPE, food and wrappers, were observed on various surfaces in the room. Housekeeper "I" was observed filling a clear trash bag with the garbage observed in the room including PPE. Housekeeper "I" exited the room with the single bag of trash, left the door ajar, walked down the hall and placed the garbage bag into another bag that was attached to a housekeeping cart located in the hallway. Housekeeper "I" then traveled down the hall from where the cart was placed and entered into room 223. It was noted that Housekeeper "I" was still wearing the same surgical mask that was observed upon entry into the previous room. Housekeeper "I" was observed picking up trash, including PPE from the room, placed it in a single clear bag, exited the room leaving the door ajar, again taking the clear bag of garbage out of the room and placing it in the same bag that was attached to the cart. Housekeeper "I" then was asked by a staff member to assist in room 232. Room 232 was occupied by two residents. Housekeeper "I" assisted the staff person, left the room, returned to the housekeeping cart, with the bag of garbage attached and left the unit with the housekeeping cart.

A phone conversation with Housekeeping

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Supervisor (HS) "J" was conducted on 1/7/21 at approximately 9:20 AM. HS "J" was queried as to how resident rooms for those diagnosed with COVID-19 should be tended to. HS "J" reported that housekeeping staff were to wear N95 Masks, shields and gowns when entering the rooms and upon exit the staff were to dispose of all PPE, trash and rags in a double bag and then immediately take the bags to the soiled utility room.

On 1/6/21 at 10:00 AM, an interview with the facility's DON was conducted regarding the facility's unit layout as it related to COVID-19. The DON explained the Daisy unit (Rooms 200-215) continued to be used as their 14-day COVID-19 observation unit, and on 1/5/20 the Rose unit (Rooms 240-257) had been converted over to a unit for COVID-19 positive residents. At that time, The DON was asked about PPE usage on the units and indicated that on the Daisy unit an N95 mask and face shield were required in the hallway, and when entering a resident room, individuals should don an isolation gown and gloves. He further explained on the Rose unit an N95 mask, face shield, and isolation gown were worn in the hallway and gloves were to be donned upon entering resident rooms and doffed upon exiting the room.

On 1/6/21 at 10:20 AM, an observation of the Daisy unit (14-day observation unit) was conducted. At 10:25 AM, Registered Nurse (RN) 'B' was observed to enter room 202. RN 'B' had on an N95 mask, face shield, and isolation gown. RN 'B' was not observed to don gloves upon entering the room. At 10:28 AM, after exiting the room; RN 'B' was queried about the use of gloves in an isolation room and said they only had to put gloves on if they were touching the resident.

On 1/6/21 at approximately 10:30 AM, an

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	interview with the Certified Nursing Aide (CNA) 'C' was conducted. CNA 'C' was asked about their assignment and said they were assigned to work on the Daisy unit, and they were also going over the Rose unit (COVID-19 positive unit) to assist the CNA over there. When preparing to exit the unit, no wipes for cleaning equipment could be located on the hall. CNA 'C' and RN 'B' were asked about where cleansing wipes were stored. CNA 'C' and RN 'B' checked the carts in the hallway, the medication cart, and the vestibule area. They were not able to locate any cleaning wipes. RN 'B' left the unit to retrieve some wipes and CNA 'C' said there were wipes on the unit earlier in the morning but thought a staff member from another unit came and took them. On 1/6/21 at approximately 10:30 AM, an observation was made of the Poppy unit. Prior to entry, residents were observed in the open area near the television. None of the residents were wearing masks. Upon entry to the Poppy unit, additional residents were observed, some had on masks, others did not. Nurse "P" was observed wearing a surgical mask that did not cover her nose. On 1/6/21 at approximately 11:30 AM, Nurse "P" was again observed not wearing a surgical mask that covered her nose. Nurse "P" was asked as to the protocol regarding PPE in the facility. Nurse "P" reported personal issues intervened with wearing the mask properly and covering their nose. On 1/6/21 at 10:55 AM, a cart of PPE was observed outside of the double doors leading into the Rose unit, the COVID-19 positive unit. It was also noted a large round trash can was observed next to the clean PPE cart. An observation down the Rose unit hallway was conducted through the window of the closed double doors. At that time,			

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Activity Staff 'D' and Social Worker 'E' were observed in the hallway of the unit. It was observed neither staff member's gown was securely tied around the waist and the gowns were flapping as they walked down the hallway. The staff were observed to enter and exit resident rooms on the hallway. At approximately 11:05 AM, Activity Staff 'D' and Social Worker 'E' exited the double doors from the unit, doffed their isolation PPE that had been worn on COVID-19 unit and disposed of it in the large trash can next to the clean PPE cart.

On 1/6/21 at approximately 11:10 AM, an observation on the Rose unit was conducted. It was noted the first door on the left inside the unit's double doors was a soiled utility room. During the observation of the unit, Maintenance Staff 'F' was observed in the hallway. Maintenance Staff 'F' was observed to be entering and exiting several rooms (occupied and unoccupied) with a toilet plunger in their hands. Staff member 'F' was noted to be wearing an N95 mask, face shield, isolation gown, and gloves. Staff member 'F' was not observed to be changing their gloves or performing hand hygiene between entry and exit of the various rooms. At approximately 11:20 AM, Staff member 'F' was asked about what was going on in the unit and they indicated there were some plumbing issues, so they were going into every room and flushing the toilets.

During the observation of the Rose unit on 1/6/21, a portable, clear, plastic partition device was observed to be cordoning off the last couple rooms and an access hall to the medication room, nursing station, and hallway to the main lobby. RN 'G' (the nurse assigned to the Rose unit) was queried about why the partition was in place and they indicated they did not know why it was there. At approximately 11:25 AM, RN 'G' was observed preparing to enter a resident room on

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the unit. RN 'G' had on an N95 mask, a face shield, and a disposable isolation gown. RN 'G' was observed to don a second disposable isolation gown prior to entering the resident ' s room. When RN 'G' exited the room, they were queried about donning a second gown and they said it was just what they did, and they weren't sure. RN 'G' was asked about what kind of education they received on PPE use on the COVID-19 positive unit and RN 'G' stated, "This just happened (the COVID-19 outbreak), I don't know it changes daily."

On 1/6/21 at approximately 4:00 PM, a review of a facility provided document that listed the facility's residents who tested positive for COVID-19 was reviewed and revealed R927 tested positive for COVID-19 and had been transferred to the hospital for COVID-19 symptoms earlier in the day on 1/6/21. A review of the facility census indicated R927 resided on the Lily unit (Rooms 220-237) and had a roommate (R928) at the time of their positive diagnosis.

On 1/6/21 at 4:25 PM, R928 was observed in their room, sitting on their bed. There was no evidence (signs, isolation cart, or PPE) R928 had been placed in transmission-based precautions, despite their exposure to their roommate (R927) who tested positive for COVID-19 earlier in the day on 1/6/20.

On 1/6/21 at approximately 4:25 PM, an observation was made on the Lily unit. Again, the doors to rooms 223, 227 and 229 were observed ajar. All other rooms on the unit were observed with doors open. Residents were seen in the hallways, some were wearing masks, others were not. One resident expressed feelings of nausea. There were no staff observed on the unit. At approximately 4:38 PM, CNA "K" was observed

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on the hall wearing a surgical mask and eye protection. CNA "K" reported that they were the only CNA assigned to the hall as the other CNA assigned had tested positive for COVID-19. When queried as to whether CNA "K" had received any training pertaining to the new outbreak of COVID-19 and was advised that at least five residents who formally resided on Lily had tested positive, CNA "K" reported that he had not received any training/education following the outbreak. When queried as to the location of the Nurse assigned to the unit, CNA "K" reported that they believed the nurse was trying to locate medication.

On 1/6/21 at 5:05 PM, an interview with the facility's DON was conducted regarding R927 and R928. The DON said R928 was cognitively intact and had been made aware of his roommate's positive COVID-19 diagnosis. The DON continued to explain R928 was asymptomatic, was being monitored for signs and symptoms, and had agreed to stay in their room in "quarantine". The DON was asked about implementing transmission-based precautions and indicated they did not put R928 on transmission-based precautions.

On 1/7/21 at 8:45 AM, the DON said the facility had decided to put the entire Lily unit on transmission-based precautions.

On 1/7/21 at approximately 9:00 AM, a tour of the Lily unit was conducted, and it was observed the entire unit had been placed on transmission-based precautions.

On 1/7/21 at approximately 12:00 PM, a review of the facility's updated resident positive COVID-19 list was conducted, and one additional resident who resided on the Daisy unit (the 14-day observation unit) had tested positive.

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On 1/12/21 at approximately 9:00 AM, a review of the facility's updated resident positive COVID-19 list was conducted and revealed that on 1/9/21, 14 additional residents who resided on the Lily unit tested positive for the virus. R928, (who was not placed on transmission-based precautions after their exposure to R927 on 1/6/21) was among the residents who tested positive.

On 1/12/21 at 10:20 AM, an observation of the Lily unit was conducted. It was observed that at the end of the hall, a temporary, translucent, plastic, zippered wall was cordoning off the last few rooms. At that time, an interview with RN 'R' was conducted regarding the zipper wall divider, and its purpose. RN 'R' did not know the purpose of the temporary wall.

On 1/12/21 at 1:50 PM, an interview was conducted with R912 in their room on the Lily unit. R912 was in transmission-based precautions for testing positive for COVID-19 on 1/9/21. In preparing to exit the isolation room, it was observed the garbage can was at the foot of R912's bed, bed #2, furthest from the door towards the window, approximately 15-20 feet away from the door. The garbage can was observed to have used PPE such as gowns and gloves contained in it. At that time, R912 asked, "Shouldn't that garbage be closer to the door, not over here by me?"

On 1/12/21 at approximately 1:55 PM, other rooms on the Lily unit were observed from the hallway for placement of the trash cans used for disposal of PPE and the following was observed: no garbage can observed in room 221 or room 227, the garbage can in room 222 was over at the foot of bed #2, and the garbage can in room 224 (containing discarded PPE) was right at the bedside of bed #1.

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On 1/12/21 at 2:50 PM, an interview with the facility's DON was conducted. The DON was asked about the plastic partition on the Lily unit since RN 'R' did not know. The DON indicated the residents beyond the partition were COVID-19 negative on 1/9/20 but were considered exposed and were under a 14-day observation. The DON was also asked where in a transmission-based precaution room the garbage cans should be located for the disposal of used PPE when exiting a room. The DON indicated the trash bin should be near the door.

On 1/13/21 at approximately 9:30 AM an interview was conducted with Nurse "L". Nurse "L" was assigned on the North Unit. Nurse "L" reported concerns regarding staffing in the Facility. Nurse "L" was queried as to whether any COVID-19 residents resided on the unit, the Nurse indicated that Male R925 had been transferred from the Daisy "Observation" unit to the North Hall Unit and was placed in a private room but shared a bathroom with two female residents. R925 was attempting to utilize the shared bathroom and was transferred to the Mum unit on 1/12/21 and was sharing the room with R926. Nurse "L" reported that at no time on the North unit was R925 was on transmission-based precautions.

On 1/13/21 at approximately 10:30 AM, a review of R925's clinical record was conducted and revealed they were admitted to the facility on 12/22/20 to the Daisy unit for a 14-day observation. R925's clinical record, medication administration record, and treatment administration record did not indicate R925 had any increased respiratory assessment and/or monitoring for the virus. R925's orders were reviewed, and it was discovered R925 had a physician's order with a start date of 1/6/21, and an end date of 1/21/21 that read, "Place resident in transmission-based precautions related to

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positive or suspected COVID-19 status." Further review of the record included a note dated 1/12/21 that read, "...resident tested COVID positive today...resident will be moving to an isolation unit." A review of R925's census information was conducted and revealed on 1/11/21 they were transferred from the Daisy unit (14-day observation unit) to the private room on the North unit, then on 1/12/21 was transferred to the room on the Mum unit with a roommate, R926.

On 1/13/21 at approximately 10:40 AM, a review of R926's physician's orders was conducted and revealed an order dated 1/13/21 that indicated they were to be placed on transmission-based precautions, after their exposure to COVID-19 positive R925.

An interview regarding R925 and R926 was conducted with the facility's DON on 1/13/20 at approximately 1:30 PM. The DON was queried about R925's COVID-19 status and why they had been moved from the Daisy unit (14-day observation unit) to two different rooms on the other side of the building (The North unit and the Mum unit). Additionally, the DON was queried why R925 had been placed in a room with R926 when R925 had orders for transmission-based precautions and R926's orders for transmission-based precautions were first placed on 1/13/20. The DON had no explanation for why R926 had been placed in the same room as R925.

On 1/13/21 at approximately 10:30 AM, an interview was conducted with the Assistant Administrator regarding the names of the Infection Preventionists employed by the Facility. The Assistant Administrator reported that the facility currently had two (the DON and Nurse "Q") acting as Infection Preventionists. It was reported that Nurse "Q" was not at the Facility at

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	the time of the interview. On 1/13/21 at approximately 10:40 AM, a phone interview was conducted with Nurse/Infection Preventionist/Staff Development "Q". Nurse "Q" was queried as to her role at the Facility and reported that she had completed her Infection Prevention training in November 2020 but was not able to work as a Preventionist/Staff Developer as the Facility was so short staffed. Nurse "Q" indicated that she never had a chance to utilize her skills as a Preventionist/Staff developer and had been working mainly on the units caring for residents in the Facility. A review of a facility provided policy titled, " Infection Prevention and Control Program" with a revision date of 8/20/20 was conducted and read, "Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections..."			