

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 235266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2020
NAME OF PROVIDER OF SUPPLIER ADVANTAGE LIVING CENTER - SOUTHGATE		STREET ADDRESS, CITY, STATE, ZIP 15400 TRENTON ROAD SOUTHGATE, MI 48195	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0880 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on interview and record review the facility failed to properly contain COVID-19 for one sampled resident (R#1) from a total sample of three residents reviewed for infection control, resulting in the potential for the spread of infection. Findings include: On 3/31/20 at 11:20 am upon entering the facility the Administrator indicated that (R#1) had been discharge to the hospital from the [MEDICAL TREATMENT] unit and subsequently tested positive for COVID-19 (highly contagious infectious disease caused by a new virus). Record review revealed that R#1 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The 2/4/20 Quarterly Minimum Data Set Assessment (MDS) indicated the resident cognition was intact. Review of the Nurse Practitioners notes documented: -3/18/20 Respiration Rate (RR) 18 and shallow, yet non-labored, and SpO2 (oxygen concentration) of 97% on 2LPM (liters per minute) via NC (nasal cannula) during rest while conversing. One hour RA (room air) trial revealed SpO2 between 89% and 93% @ rest. BS (breath sounds) are diminished bilaterally with faint scattered expiratory wheezing. RT (Respiratory Therapist) administered [MEDICATION NAME] NMT for wheezing, without incident. -3/25/20 PULM: RR regular and labored, Noted wheezes, crackle, rhonchi, 02 @ 1 NC PRN (as needed). Assessment/Plan: 1. SOB/cough non productive usually at night, request a small cup of water. order for rescue inhaler and breathing tx Q 6 hrs ordered chest X-ray. -3/26/20 Change of Condition Note: Resident noted with changes ton general condition mostly increase coughing and discomfort to chest area, breathing treatments administered and cough syrup given every 6 hrs as needed. Chest x-ray ordered and performed, result-right sided upper lobe interstitial/airspace opacity concerning for developing pneumonia. Ordered (name of antibiotic) for 10 days. -3/27/20 Chief Complaint: pneumonia. I was asked by nursing staff to see this patient for cough/SOB. -3/27/20 Infection Note. Resident sitting up in wheelchair in room watching TV. Slight crackles noted to upper right chest. Left side clear to auscultation. Temp 99.9 tympanic. Resident denies SOB, pain or chest discomfort. -3/27/20 Restorative Weekly Progress Notes: resident refused restorative care stating that he does not feeling well resident was requested x 3. -3/28/20 Resident continue on (Name of antibiotics) for suspected pneumonia, Patient lung sounds-minimal crackles and wheezes to left lobe. [MEDICATION NAME] via neb (breathing treatment), elevated temp-T-100.0 degrees, Tylenol 650 mg (milligram) given, will monitor closely. -3/28/2020 Appointment departure note: Resident loa (leave of absence) to [MEDICAL TREATMENT]. -3/28/2020 14:15 Health Status Note: Resident sent directly to (Name of hospital) from (Name of [MEDICAL TREATMENT] center) daughter concerning condition stated she spoke to emergency room doctor and they informed her they will be testing him for COVID-19 and results will be acknowledged in 24-48 hours. At 2:28 pm during an interview with the Administrator and Director of Nursing they were asked about the facility COVID-19 policy on isolation for a high risk resident who deveolped signs and symptoms 3 days prior to transferring to [MEDICAL TREATMENT]. The Administrator said the Nurse Practitioner was treating the patient for Pneumonia, therefore she felt isolation was not needed. The Administrator went to say that the resident should have been placed into droplet contact precautions when the resident developed the respiratory concerns and increased temperture. Review of the policy titled, Management of Outbreak of a Communicable Disease (COVID-19) updated 3/11/20 documented, Initiating isolation barriers as directed or as necessary. If a current resident begins showing S/S and you suspect COVID-19 you should place in droplet contact precautions and notify the physician and local health department. If the test comes back positive or the resident condition deteriorates, you will likely be advised to transfer to an acute care setting.</p>		

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.