STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235705	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HELEN NEWBERRY JOY HOSPITAL LTCU	502 W HARRIE ST NEWBERRY, MI 49868

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to properly maintain infection control practices during a COVID-19 Infection Control Survey when they failed to adequately screen those entering the facility, failed to place newly admitted residents in quarantine, and failed to ensure the appropriate use and/or storage of Personal Protective Equipment (PPE) and medical equipment. This deficient practice resulted in the potential for the spread of COVID-19 (a highly transmissable [MEDICAL CONDITION] infection) which could impact all of the residents in the facility. Findings include: On 4/28/20 at 10:00 a.m., Surveyors were met at the facility entry by Certified Nurse Aide (CNA) D, who answered the facility doorbell. Upon entering the facility entryway, this Surveyor observed a bedside table with (brand name) bleach wipes, an employee/visitor sign-in log, and a (brand name) digital oral thermometer. The Director of Nursing (DON) arrived soon after, and asked the Surveyors to complete the sign-in log, and take and document their own temperatures. There was no written process found directing those entering how to check-in, or directions for how to use the digital thermometer. It was noted there were plastic thermometer sleeves attached to the digital thermometer in a box. It was not clear how or when the sign-in log was monitored, or a process to sanitize the thermometer stem and unit. It was noted there were several steps involved to use this digital thermometer unit. A review of a blank Employee/Visitor sign-in log, untitled, provided by the DON, was absent of any questions regarding any international travel within the last 14 days, recent trips on a cruise ship, or contact with someone with known or suspected COVID-19. The screening check-in form did not include these required elements per CDC (Center for Disease Control) guidance. During an interview on 4/28/20 at 10:20 a.m., the DON was asked to clarify the Employee/Visitor entry process. The DON reported the screening was done by the employee on their own: they fill out the log and take their own temperature. During an interview on 4/28/20 at 11:45 a.m., LPN Intern/Staff E was asked about the employee/visitor sign-in process. Staff E conveyed there was sometimes a staff member checking in staff when Staff E arrived for work. Staff E reported they then fill in the sign-in log with their name and their temperature. When asked who takes their temperature, Staff E reported their temperature was sometimes taken by a staff member (usually a CNA), however, if they come in at an 'off' time, such as during a shift change, they take their own temperature. Staff E confirmed they have taken their temperature themselves upon entry. During an interview on 4/28/20 at approximately 3:15 p.m., the DON was asked how and when the sign-in logs are reviewed. The DON stated during the day shift the manager on duty picks up the screening log, and reviews it after the employees sign-in. The DON stated they review the screening log for the night shift the next morning, after arriving for their shift. The DON reported staff have been educated to call a nursing supervisor with a fever, which is noted on the sign-in log. The DON confirmed staff may take their temperature themselves upon entering the facility. A review of the facility policy titled COVID-19 (effective date 3/30/20) provided by Nursing Supervisor A, revealed, HCP (Health Care Practitioner) will be actively screened, using the following screen questions: .a. Signs and symptoms of a respiratory infection, such as fever, cough, shortness of breath, or sore throat etc. If state (sic) no signs/symptoms, including fever, take HCP's temperature and record results b. In the last 14 days, has had contact with someone with a confirmed [DIAGNOSES REDACTED]. C. International travel within the last 14 days. D. Have you been on a recent trip within the last 14 days, such as a cruise ship, or participated in other settings where crowds are confined to a common locations? .If the respiratory symptoms are consistent with COVID-19, the screener should contact (the DON) or (the Nursing Supervisor) who will contact infection control for instructions . A review of the Center for Medicare and Medicaid Services (CMS) Guidance, dated March 23, 2020, document 'QSO-20-20', revealed, .CMS is providing the following expanded guidance to prevent the spread of COVID-19: Visitors (including employees) should receive the same screening as patients, including whether they have had: Fever or symptoms of a respiratory infection, such as a cough and sore throat. International travel within the last 14 days to CDC Level 3 risk countries .Contact with someone with known or suspected COVID-19 .Facilities should screen and limit visitors for any recent trips (within the last 30 days) on cruise ships as well as close contact with a suspect .or confirmed COVID-19 patient within the last 14 days, or overseas travel from certain countries. On 04/29/20 at 11:51 a.m., An observation was made of Resident #101's room. A PPE equipment rack containing contact gowns and gloves was hung over the door. Droplet and contact precaution signs were posted on the door. Containers of disinfectant were not observed. Certified Nurse Aide (CNA) I was observed leaving Resident #101's room. CNA I was wearing a contact gown, gloves, an N-95 face mask and goggles. CNA I removed their gown and gloves prior to leaving the room, washed their hands, then placed the goggles and N-95 face mask into a paper bag. The goggles were not disinfected, CNA I was asked if the goggles disinfected prior to the next use. CNA I replied, I was wondering about that, we were told to put them (the goggles) in a paper bag with the masks. CNA I had not been instructed to disinfect the goggles. A review of Resident #101's Electronic Medical Record (EMR) revealed an admission date of [DATE]. Resident #101 had medical [DIAGNOSES REDACTED].(provider) notified and new orders rec'd (received) for CXR (chest x-ray) and nasal swab for COVID-19 test. Res. moved to private room [ROOM NUMBER] and placed in droplet precautions until test results are rec'd. On 04/28/20 at 1:44 p.m., Infection Preventionist/Registered Nurse (RN) B was asked about process of disinfecting goggles when leaving a droplet precaution room. RN B reported the goggles should be removed when leaving the room. There should be a station set up outside of the room to clean the goggles. When the observation of goggles being placed inside of a paper bag with the N-95 mask were shared, RN B stated that should not be happening. During an interview on 04/29/20 at 3:14 p.m., the Director of Nursing (DON) was asked what the expectation was for goggles when staff came out of a droplet precaution room. The DON reported goggles should be disposed of in the garbage. The DON agreed goggles should not be placed inside of the paper bags and clarified the paper bags were only used for N-95 mask storage. On 04/29/20 at 11:34 a.m. Resident #102's room door was observed with a PPE rack hung on the door which contained contact gowns and gloves. A contact precaution sign was posted on the door. A dedicated blood pressure cuff, thermometer, oxygen saturation monitor (a device used to measure oxygen levels), and stethoscope were not observed in Resident #102's room. On 04/29/20 at 12:24 p.m., CNA I was asked about any dedicated medical equipment in Resident #102's room. CNA A replied, I don't think there is any in there. CNA I observed Resident #102's room and verified there was not a dedicated blood pressure cuff, thermometer, oxygen saturation monitor, and stethoscope in the room designated as a contact precaution room. In a follow up interview with CNA I on 04/28/20 at 12:28 p.m., CNA I reported contact precaution rooms should have medical equipment that stays in the rooms. CNA I was not sure why they equipment was not in Resident #102's room and did not identify a shortage of equipment as a problem. During an interview on 04/28/20 at 1:32 p.m., with Unit Manager/RN A and RN B, RN A reported Resident #102 had been placed in contact precaution due to [MEDICAL CONDITION] Resistant Staphylcoccous Areus (MRSA- an infection which is difficult to treat due to its resistance to several antibiotics) in their wound. RN B stated the expectation was for any contact precaution room to have a dedicated blood pressure cuff, thermometer, oxygen saturation monitor, and stethoscope in the room. In an interview on 04/29/20 at 3:14 p.m.,the DON confirmed the expectation was to have dedicated medical equipment in a contact precaution

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) room. The facility's Initiation/Termination of Isolation policy dated, with the most recent review date 11/01/19 did not contain any information pertaining to the disinfection or disposal of PPE. During an interview with RN A on 04/28/20 at 1:32 p.m., RN A was asked if there was any policy in place for isolating newly or readmitted residents. RN A replied they did not think so. The only admissions were coming from the acute care setting of the building which the facility was adjacent to. RN A reported Resident #101 had been admitted into a room with a roommate and then had been transferred to a droplet precaution room because they had developed respiratory symptoms and was awaiting COVID-19 test results. On 04/28/20 at 3:14 p.m. the DON stated there was not a policy at this time to put newly or readmitted residents into quarantine COVID-19. The following guidance was retrieved from The Centers for Disease Control (CDC) website on 04/29/20: Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options may include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. Residents could be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their exposure (or admission). Testing at the end of this period could be considered to increase certainty that the resident is not infected. If an observation area has been created, residents in the facility who develop symptoms consistent with COVID-19 could be moved from their rooms to this location while undergoing evaluation. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html).