STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235257	A. BUILDING _____ B. WING _____	05/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IRON CO MEDICAL CARE FACILITY	1523 U S HIGHWAY 2 CRYSTAL FALLS, MI 49920

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

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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. This deficient practice resulted in the potential for transmission of COVID-19 which had the potential to affect all 155 residents residing in the facility. This citation has four noted facility deficiencies: 1. Failure to ensure appropriate Personal Protective Equipment (PPE) use to prevent potential transmission of infectious organisms, including COVID-19. 2. Failure to perform hand hygiene prior to medication administration. 3. Failure to isolate a presumptive positive COVID-19 resident (R#3) in a private room. 4. Failure to move a presumptive positive COVID-19 resident and newly admitted and readmitted residents into the facility identified Quarantine Unit (CEDAR). Findings include: On 5/5/2020 the following nine (9) cloth (hand-made) facemask observations were noted: 9:38 a.m. - Registered Nurse (RN) B's facemask was below her nose. RN B touched the front of the facemask multiple times with bare hands and pulled the facemask below her mouth to speak. No hand sanitation performed. 9:47 a.m. - Restorative Aide (Staff) D's facemask was below her nose. She pulled the facemask down lower to speak, and touched the front of her facemask three times without hand sanitation. 9:52 a.m. - Assistant Operations Supervisor (Staff) F, was in a resident kitchen with the folded facemask on the counter near uncovered cookies being prepared by Dietary Aide G. Staff F picked up the facemask from the counter, forcibly blew into the interior of the mask, and placed it on his face. No hand sanitation was observed. During an interview at this same time, Staff F stated, .I shouldn't have been in there (Resident kitchen) doing that (face mask off/blowing on mask). 9:56 a.m. - Dietary Aide G was observed with her facemask below her nose. 10:00 a.m. - Housekeeper Staff H's facemask was below her chin, not covering her nose or mouth. 11:30 a.m. - Laundry Staff O's facemask was below her nose. Her bare hand touched the front of the mask to pull it up into position. No hand sanitation was observed. 11:32 a.m. - Medical Assistant (Staff) Q's facemask was below her nose as she leaned over to speak with an unidentified Resident in a wheelchair. Staff Q then used her bare hand to pull the face mask out from her face, allowing a large gap between her mask and her face while she continued to speak with the Resident. 11:41 a.m. - Licensed Practical Nurse (LPN) R's facemask was positioned below her nose. LPN R repositioned the mask several times by touching the front of the mask with bare hands and removed it to speak. No hand sanitation was observed. 12:55 a.m. - Dietary Aide S's facemask slipped off her nose, and was adjusted with bare hands, by pushing on the front of the face mask. On 5/5/2020 at 10:06 a.m., when asked about donning of facemasks in facility kitchens with regard to COVID-19, Dietary Manager (DM) K confirmed a mask was required to be worn while in the kitchen, and stated there was potential for transfer of COVID (COVID-19) to food (and) to residents. Review of the facility Mandatory Use of Cloth Masks policy, Effective Date 4/8/2020, revealed the following: (Facility Name) will provide its employees with community-made cloth masks (as availability allows) to wear while at work. These masks may decrease the risk of COVID-19 spread from one employee to another or an employee to a resident .Process: 2. Masks will be considered part of the employee's uniform and should be maintained accordingly .NOTE: Donning and doffing masks and changing filters should be done with care to avoid contamination of the worker, near-by surfaces and others. Hands should be washed before and after removing a filter and donning and doffing a mask . Review of the Centers for Disease Control and Prevention (CDC) Using Personal Protective Equipment (PPE), webpage last reviewed April 3, 2020, retrieved 5/6/2020 at 10:51 a.m., revealed the following: .Respirator/facemask should be extended under chin. Both your mouth and nose should be protected (covered). Do not wear respirator/facemask under your chin .Do not touch the front of the respirator or facemask .Carefully untie (or unhook from the ears) and pull away from face without touching the front . During an interview on 5/5/2020 at 2:16 p.m., when asked about facemasks used by facility staff, Infection Control/RN A stated, They (facility staff) should not wear it (facemask) below their nose. They should be pulling it up over their nose. People pull it out so they could talk - they should not (do that). Housekeepers should be wearing their cloth masks at all times . During this interview, RN A's cloth facemask was observed falling below her nose. During an observation on 5/5/2020 at 10:35 a.m., RN E exited room [ROOM NUMBER], shutting the door with a bare hand on the exterior doorknob. No hand sanitation was observed. RN E immediately went to the medication cart, pulled out a plastic cup, and set it on the medication cart. RN E then entered and exited the nurse's office by using a bare hand on the door handles. No hand sanitation was observed. RN E returned to the medication cart, opened a container of fiber supplement for Resident #8, and placed the dry fiber supplement into the plastic cup. RN E obtained water, to add to the fiber supplement in the cup, from Resident #8's bathroom sink. RN E administered the fiber supplement to Resident #8, without any hand hygiene during the entire process. Review of the facility Hand Hygiene policy, reviewed/revised 2/2020, revealed the following: All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors . The Hand Hygiene Table, copyright 2019, attached to the Hand Hygiene policy listed the following conditions where hand hygiene should be performed: After handling contaminated objects .Before preparing or handling medications . During an interview on 5/5/2020 at approximately 2:30 p.m., when asked about preparation and administration of medications following contact with potentially contaminated surfaces, such as doorknobs, the Director of Nursing (DON) stated, The expectations are hand sanitizing (is performed). On 5/5/20 at 9:35 a.m., during an initial tour observation on BIRCH UNIT, Resident #3 and Resident #4 were cohorted in the same room with the door left wide open. Droplet and contact isolation signage and PPE supplies were outside their room door. Resident #6's room door was also left wide opened with droplet and contact isolation signage and PPE supplies. During an interview on 5/5/20 at 9:50 a.m., RN Q confirmed Resident #6 was in quarantine isolation for COVID-19 due to a recent facility admission and that Resident #3 was presumptive positive for COVID-19 with active signs and symptoms. Review of Resident #'6's History and Physical, 4/25/2020, read, .was sent to the hospital on [DATE] due to extreme lethargy. She was found to be in acute [MEDICAL CONDITION] .and was subsequently admitted .discharged back to the nursing facility on 4/22/2020 . Review of Resident #3's medical record and Progress Notes revealed: Minimum Data Set (MDS) assessment (4/11/2020), revealed Resident #3 was admitted to the facility on [DATE] with the following major Diagnoses: [REDACTED]. On 5/4/2020 at 01:37 (1:37 a.m.) read, Resident has increased (sic) and wheezing .Did place on contact and droplet precautions . On 5/4/2020 at 13:41 (1:41 p.m.) read, .Due to COVID-19 monitoring, resident will need to be on precautions until he can be further evaluated and tested . On 5/4/2020 at 18:13 (6:13 p.m.) read, .New order to have COVID-19 testing performed in house due to increased cough. On 5/5/2020 at 17:03 (5:03 p.m.) read, .did have a nasopharyngeal COVID-19 test performed this morning . On 5/5/2020 at 21:20 (9:20 p.m.) read, .hoarse voice, upper airway wheezing, harsh cough, some lethargy (fatigue) . During an interview on 5/5/20 at 1:15 p.m., Infection Control/RN A identified their Quarantine Unit as being CEDAR. RN A verified 14-day COVID-19 quarantine residents from recent hospital admissions (including Resident #6) were located on three separate units (BIRCH, CEDAR, and SKYWAY) along with other residents not requiring isolation nor quarantine. When asked why these quarantined residents and Resident #3 were not moved to CEDAR since 13 vacant rooms were available, RN A stated the plan was in process but the facility had not yet authorized the room transfers due to staffing

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) needs. When asked why Resident #3 had not been placed in a private room, RN A said that was something that could be considered. During an interview with the DON and RN A on 5/5/20 at 2:10 p.m., the DON confirmed the dedicated Quarantine Unit was CEDAR. When asked why the residents from BIRCH and SKYWAY had not been moved, the DON indicated staffing and PPE supplies were still being worked out. When RN A was asked what PPE was worn during Resident #3's COVID-19 nasopharyngeal sample collection, RN A indicated she had not worn a N95 mask (respiratory mask with a close facial fit designed to provide high-level particle filtration). RN A indicated N95 masks were available. Review of facility provided, Isolation Quarantine List dated 5/5/20, indicated eight residents who required quarantine were currently on three different units (BIRCH, CEDAR, and SKYWAY). Review of facility provided, Transmission-Based Precautions for a Suspected COVID-19 Resident or Quarantine Resident During Personal Protection Equipment Shortage (Implemented 4/10/2020 and last Revised 5/4/2020) read in part, current residents who develop signs and symptoms of COVID-19 will be moved to the Quarantine Unit .Residents Returning from Inpatient Stays: returning residents will be housed on the Quarantine Unit for observation for 14 days . Review of facility provided, COVID-19 Testing of Residents (effective date 4/17/2020) read in part, Procedure for Obtaining Sample .1. Gown, gloves, mask (N-95 if available), facesheild worn by collector . Review of facility provided, Novel Coronovirus Prevention and Response (undated), read in part, 6. Procedure when COVID-19 is suspected: .B. Place resident in a private room (containing a private bathroom) with the door closed .