STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235352	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASS COUNTY MEDICAL CARE FACIL	**23770 HOSPITAL ST CASSOPOLIS, MI 49031**

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** - Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to properly maintain infection control practices during linen delivery for a COVID-19 Infection Control Survey. Findings include: Review of the Laundering Personal Clothing Policy dated 7/3/14, revealed .7. Hang up residents clothing on the clothing rack (by wing) 8. Deliver clothing to residents room. During an observation on 9/2/20 at 11:30 AM, noted laundry staff wheeling clothing racks from the laundry room to each of the 3 resident halls of the facility. Clothing racks were not fully enclosed - a sheet was placed over the top of each of the racks, leaving the bottom portion of the rack and clothing exposed. During an observation and interview on 9/2/20 at 11:42 AM, noted one clothing rack parked approximately halfway down the hall touching the handrail on the wall. Certified Nursing Assistant (CNA) E approached the rack, pulled the sheet from one side of the rack up to the top of the rack to expose the clothing, removed one resident's clothing, re-covered the laundry and delivered to resident room. Housekeeping/Laundry (HL) F approached the rack from the opposite end, pulled the sheet up to the top of the rack to expose the clothing, removed one resident's clothing, and delivered to resident room. HL F did not re-cover the exposed clothing with the sheet, leaving the clothing exposed while unattended. During this time, the hanging laundry was noted to be touching the wall, and all hanging items were dragging against the hand railing. (The wall and the hand railing are high-touch items, meaning that staff and residents touch these areas often, thus potentially contaminating the area). At no time during the observation was the contaminated laundry that had touched the handrail returned to laundry for re-cleaning. During an interview on 9/2/20 at 11:50 AM, CNA E reported that we normally take just one resident's laundry at a time and re-cover the laundry each time, and the small items in the boxes at the bottom of the laundry cart are supposed to be in separate bags for each resident. During an observation on 9/3/20 at 12:04 PM, Resident #103 was wandering in a wheelchair in the hallway, Director of Nursing (DON) C stopped to adjust Resident #103's mask over his nose as he self-propelled his wheelchair touching hand rails going down the hall. DON B cleaned her hands after assisting Resident #103. During an interview on 9/3/2020 at 1:47 PM, Environmental Service Director (ESD) Q reported that HL F came back to the laundry and that she spent some time talking to HL F and that the employee had been with us for about 5 months, but she did not understand what was going on. ESD Q reported that HL F had not told her about the cover sheet being removed and not placed back over the clothing, that some of small items were not in bags, and the clothing was dragging against the hand rails. ESD Q reported that she had put a new policy for clothing in place.

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.