STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235019	A. BUILDING _____ B. WING _____	05/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JACKSON COUNTY MEDICAL CARE FACILITY	524 LANSING AVE JACKSON, MI 49201

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.** Based on observation, interview and record review the facility failed to ensure staff competence for disinfecting resident equipment for a census of 175 residents, resulting in the potential for Covid-19 infection to residents and staff. Findings include: On 05/20/2020 at 9:15 AM, an unlabeled clear plastic shoe box with a gray lid, filled with moistened cloths, was observed in a cupboard the therapy room. There were no instructions near or attached to the shoe box container of wipes. During an interview with Physical Therapist (PT) D on 05/20/2020 at 10:30 AM, he stated the contact time, for cleaning equipment with the wipes from the plastic shoe box, was five minutes. In an interview on 5/20/2020, at 9:25 AM Registered Nurse (RN) P, who was the Unit Manager on the 100 unit, stated that Environmental Services Director (ESD) U made the cleaning wipes the staff used to disinfect equipment, and said the wipes had a 3 minute contact time (time required for the item to be wet with the disinfectant in order for the disinfectant to be affective). RN P said she did not know what the cleaner and disinfectant was that ESD U put on the wipes. RN P said staff used the wipes ESD U made to clean the mechanical lifts, wheelchairs, and accu checks machines after resident use. In an interview and observation on 5/20/2020, at 10:03 AM, Licensed Practice Nurse (LPN) S, who was working on the 100 unit, stated that a disinfectant wipe was used for cleaning and disinfecting equipment, and was then observed to look in the medication cart drawer for the canister of wipes, but was not able to locate them. At this time RN P approached LPN S and stated to LPN S that peroxide cleaning and disinfectant wipes, which were observed to be in a plastic shoe box at the nursing station, were to be used for cleaning of equipment, and then revealed to LPN S the contact time for the cleaning wipe was 3 minutes. LPN S stated that she was not told to use the peroxide wipes in the shoe box, nor was she instructed on the contact time of 3 minutes. In an observation and interview on 5/20/2020, 10:30 AM, with a confidential staff member (CSM), CSM provided observation in the shower room of the spray bottle of cleaner and disinfectant that she used to clean resident equipment. CSM opened a cupboard in the shower room to retrieve the spray bottle used to clean resident equipment, but no spray bottle was in the cupboard. CSM said she did not know where to get the cleaner. CSM said the mechanical lifts were cleaned with the wipes that were stored in a baby wipe type container that hung onto the mechanical lift in a bag. A baby wipe container was observed to be in a bag hanging from three mechanical lifts in the shower room. No documentation was observed on the baby wipe container, nor in the bag the container was located in, that revealed what the cleaning disinfectant product was on the wipes or the contact time required. CSM stated that she did not know what the cleaner was that was on the wipes in the baby wipe containers, nor did she know what the required contact time was for the use of the wipes. CSM stated said she had not received any training on the required contact time for the cleaning wipes to be effective. In an observation and interview on 5/20/2020, at 10:46 AM, LPN T stated the wipes were used for cleaning. Observation of the wipes, with LPN T that she referred too, revealed wipes in a plastic shoe box container that were wet. The plastic shoe box was not labeled with the name of the cleaning and disinfecting product nor the contact time required for the product. The only directions observed on the box was, for use on stand-up and Hoyer lifts. LPN T stated that she did not know what the cleaner and disinfectant product was that was on the wipes, and stated that the CNAs used the wipes for cleaning of equipment, and she used them to clean off her medication cart. LPN T also stated that she did not know what the contact time was for the product on the wipes, but stated that she would say it was a couple of minutes, although she did not know. In an interview on 5/20/2020, at 11:15 AM, RN C, who was the Infection Control Preventionist, stated that ESD U had made cleaning wipes out of dry wipes with the cleaner used in the housekeeping department, because the wipes that were usually used were out of stock and on back order. RN C stated that she did not know what the cleaning product was the ESD U put on the wipes. RN C said that the contact time for the wipes made by ESD U was 3 minutes and was documented on the plastic shoe boxes the wipes were stored in at the nurses stations. RN C was informed that the product and contact time were not observed on the plastic shoe boxes, in which ESD U stated she was not aware of that. Record review of the facility's staff in-service titled, Covid 19, dated 4/10/2020, revealed no subject matter pertaining to the cleaner and disinfectant product used or required contact time for the product to be effective. Although the education consisted of a policy titled, Covid 19 Protocol, dated 4/6/2020, the policy did not contain language pertaining to the use of cleaner and disinfectants, nor the required contact time for the cleaner and disinfectant used by the facility. Record review of a, Communications, Facility Bulletin Board, dated 4/29/2020, revealed a notation by ICP C, Ensure you are properly disinfecting the glucometers, lifts, nursing cart keys, v/s (vital sign) carts, kiosks ECT. The communication did not reveal any education to staff related to the disinfectant product being used, the required contact time for the product to be effective, or how to properly disinfect the equipment. Record review of another, Communications, Facility Bulletin Board notation by ICP C, dated 5/7/2020, revealed, Ensure you are properly disinfecting equipment such as glucometers, vital sign machines and lifts after each use . The communication did not reveal any education to staff related to the disinfectant product being used, the required contact time for the product to be effective, or how to properly disinfect the equipment. Record review of a, CarePartners Only (staff communication) notation by ICP C, dated 5/13/2020, revealed, There are now wipes placed on all lifts .please ensure you are cleaning the lifts after each use . The notation did not reveal any directions to staff on the disinfectant product being used nor the required contact time for the product to be effective. Record review of the facility's policy and procedure titled, Cleaning & Disinfection of Resident-Care Items & Equipment With Power Washer, dated 5/25/2017, revealed on page #1 under Procedure, #2. .Non-critical Resident-care items include bedpans, blood pressure cuffs, crutches, and computers .Reusable items are cleaned and disinfected or sterilized between Residents (e.g., stethoscopes, durable medical equipment)., and under #3. Durable medical equipment (DME) must be cleaned and disinfected before reuse by another Resident. The policy did not reveal the product used or the required contact time for the used product to be effective. The policy only revealed that upon use of the facility's power wash system the disinfectant/detergent was to be allowed to soak for 3 minutes, but did not refer to the use of cleaner and disinfectant wipes. On 5/20 2020, an observation and interviews of staff and equipment began at 9:30 AM. On Unit 3, Licensed Practical Nurse G said more supplies were in the supply closet downstairs. There had been no shortage of supplies as far as they knew. On Unit 3, Housekeeper H showed this Surveyor the product used to clean all surfaces in resident rooms and around the unit, such as hand rails, counter tops, door knobs, drawer fronts. The Product was Peroxi Multi Service Disinfectant. The EPA registration number was 1677-238. It was stored in the housekeeper' closet and was dispensed into the buckets on the cleaning carts with a hose from the large container. On Unit 4, Certified Nurse Assistant (CNA) J was interviewed about the disinfectants used on resident equipment such as shower chairs, lifts, blood pressure stands, wheel chairs and wheel chair cushions. When asked what they used to disinfect equipment, CNA J said they had purple top containers of wipes in the nurse's station and individual packets in a plastic bag hung on each lift. CNA J was unable to locate a purple top

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) cannister, and seemed surprised. When observing a lift, the plastic bag had a brightly-patterned pull-up dispenser that resembled the personal wipes at local stores. These containers had no labels with contents or contact time. CNA J could not say what was in the wipes, nor what the contact time was. When asked, CNA J said they were not aware of running out of supplies or disinfectants. On Unit 4, Confidential Staff (Staff) showed this Surveyor how staff disinfected the shower chairs by spraying the chair with the Peroxi Multi Surface Disinfectant that was in a container fastened to the wall, and let it sit for at least 5 minutes. Then the chair was rinsed with hot water. When asked, Staff did not know that the chair was to remain wet during the 5 minute time. On Unit 3, CNA M was interviewed and said they didn't know where to get more of the disinfectant kept in the shower rooms. When asked, CNA M could not say what contact time was, but was able to answer 5-10 minutes when asked how long the disinfectant had to remain on equipment to be effective; I have to look it up on the container because they are all different, they said. CNA M could not say what was in the bag attached to the lifts, how the product was to be used and said they had never seen them before. On Unit 3, CNA N was interviewed and said they had received training about contact time, but was not told that contact time meant how long the equipment was to remain wet with the disinfectant; not how long they waited to rinse it off or use it. On 5/20/2020 at 11:20 AM, Infection Control Nurse (IC) C was interviewed. When asked who observed/audited staff for disinfecting equipment, IC Nurse C answered Unit Managers, and said, The CNAs knowing how to disinfect equipment has been a hot topic around here. On 5/21/2020 at 9:35 AM, Unit Manager (UM) V (for unit 3) was interviewed via phone. When asked, UM V said that they had talked to the aides about contact time, i.e. how long to keep the surface wet. When asked if the shoe boxes at the nurse's station and dispensers on the lifts were labeled with contents, any directions for safe use and contact time, UM V said they were. However, no labeling was observed. On 5/21/2020 at 10:30 AM, Housekeeping Supervisor U was interviewed via phone. When asked, Supervisor U said they refilled the shoe boxes with fresh disinfectant and cloths. They also refill the dispensing packets hung on the lifts. When asked about educating on the use of the two items, they believed something was put on the dashboard, and, The managers knew what I was talking about when I informed them. My people (housekeepers) know the wet time. Supervisor U did not know about education for the CNAs.