STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235410	A. BUILDING _____ B. WING _____	05/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF MUNISING	**300 W CITY PARK DR MUNISING, MI 49862**

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 Focused Infection Control Survey. This deficient practice resulted in the potential for transmission of COVID-19 (a highly contagious [MEDICAL CONDITION] infection) to all 55 vulnerable residents within the facility. This citation has five noted deficiencies: 1. Failure to complete timely infection control surveillance, including mapping to identify infection clusters. 2. Failure to perform hand hygiene to prevent transmission of infectious organisms, including COVID-19. 3. Failure to properly utilize, clean, and dispose of Personal Protective Equipment (PPE) to prevent transmission of infectious organisms. 4. Failure to quarantine residents newly admitted or readmitted to the facility for 14 days to monitor for symptoms of COVID-19. 5. Failure to maintain food safety standards to prevent transmission of infectious organisms in the kitchen. 1. On 5/14/2020 at 9:55 a.m., an Infection Control interview was conducted with Registered Nurse (RN)/Infection Preventionist A. When May 2020 infection surveillance, including mapping, was requested for review, RN A provided the May 2020, Infection Control Log with a list of five Resident names. No room numbers were present on the Infection Control Log, and no May Infection Control mapping (used to identify clusters) was available for review. RN A stated, I put the room numbers on (the Infection Control Log) after I map them (on a copy of the facility floor plan). RN A had been out of the facility for one week, and during that time the Director of Nursing (DON) had completed the infection control surveillance documentation. RN A confirmed the DON had not added the May 2020 individuals listed on the Infection Control Log into the facility Infection Watch, nor had she mapped the infections. When asked what the concern would be with the lack of infection mapping, RN A stated, .Possibly (we) would miss clusters (of infections) if you weren't mapping them. During an interview on 5/14/2020 at 11:20 a.m., when asked about mapping of the May 2020 facility infections, the DON stated, No, I did not map (the infections). I should have done it . During a repeat interview on 5/14/2020 at 11:25 a.m., the DON confirmed she had not entered resident infection data on the May 2020 map, nor had she entered any of May 2020 infection control data into the computerized infection control tracking program. Review of the facility Outbreak of Communicable Diseases policy, dated 2/2018, revealed the following: The Infection Control Coordinator and Director of Nursing Services will be responsible for: 7a. Receiving surveillance information and tabulating data; 7b. Maintaining a line listing of identified cases . The nursing staff will be responsible for: .8b. Providing infection surveillance data in a timely manner . 2. On 5/14/2020 at 12:25 p.m., Certified Nurse Aide (CNA) F was observed wearing a blue surgical mask that had an orange, fingerprint-sized stain - that appeared to resemble food, on the upper right corner of the mask. During this interview, CNA F's stained face mask fell below his nose. CNA F used a bare hand, touching the front of the mask to move it onto his nose, and touched the front of the soiled mask three more times during the interview. No hand hygiene was performed. Review of the facility Hand Hygiene policy, revised 5/11/2020, revealed the following, in part: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors .HAND HYGIENE TABLE: (when hand hygiene is performed) .After handling contaminated objects, before and after providing care to residents in isolation, after handling items potentially contaminated with blood, bloody fluids, secretions, or excretions .when in doubt . 3. On 5/14/2020 at 12:20 p.m., CNA E confirmed she had previously provided care to Resident #3, who was in droplet precautions requiring the use of PPE. A small waste basket was observed just inside Resident #3's open room door, with multiple yellow isolation gowns overflowing onto the floor. When asked about the soiled isolation gowns on the floor in Resident #3's room, CNA E stated, That is not where they (soiled isolation gowns) normally go. On 5/14/2020 at 12:23 p.m., when asked about disposal of soiled isolation gowns in Resident #3's room, RN/Unit Manager G stated, They (facility staff) are supposed to be using white buckets with yellow liners (for the soiled gowns). RN G indicated the proper equipment would be placed in the room for disposal of the soiled isolation gowns. Review of the Centers for Disease Control and Prevention (CDC) Cleaning and Disinfecting Your Facility provided by the facility, revealed the following: .Gloves and gowns should be removed carefully to avoid contamination of the wearer and the surrounding area. On 5/14/2020 at 12:25 p.m., CNA F confirmed he had donned PPE (gown, mask, face shield, and gloves) to provide care for Resident #3 on this same day. CNA F said he donned a mask, face shield, gown, and gloves to provide care for Resident #3. Two face shields, with no name (to identify the user) hung from the PPE storage container that was on the outside of Resident #3's room door. When asked how staff would know if the face shields were clean or dirty, CNA F stated, I wasn't told to clean it. CNA F confirmed no sanitization of the face shield was performed after usage that day, by CNA F. When asked if there would be a concern with wearing a previously used (soiled) face shield, CNA F stated, I don't know what happened with the last person that wore it. CNA F confirmed he had been wearing the same surgical mask all day, including into Resident #3's isolation room as well as other resident rooms. CNA F said the mask was replaced every seven days by the facility. On 5/14/2020 at 12:30 p.m., CNA H donned PPE and entered Resident #3's room. CNA H was observed to don a new surgical mask, isolation gown, face shield, and gloves, in that order. When asked to describe the order of donning PPE, CNA H confirmed donning PPE for Resident #3's droplet precautions in the above order noted. CNA H removed the face shield and used bare hands to sanitize the front of the face shield. When asked how the black porous foam that rested against a staff's forehead was sanitized following use, CNA H said it was done with a sanitizing wipe. When asked how 'clean' or 'soiled' was determined for the face shields hanging on Resident #3's door, CNA H stated, .If it is on the door it is clean. Review of the Donning PPE, Revised August 2017, posted outside Resident #3's door revealed the order of donning PPE as: gown, mask, goggles/face shield, followed by gloves. Review of the facility provided Centers for Disease Control (CDC) and Prevention - Strategies for Optimizing the Supply of Eye Protection, dated March 17, 2020, revealed the following: Ensure appropriate cleaning and disinfection between users if goggles or reusable face shields are used .If a disposable face shield is reprocessed, it should be dedicated to one HCP (health care provider) and reprocessed whenever it is visibly soiled or removed (e.g., when leaving the isolation area) prior to putting it back on . Review of six facility newly admitted and readmitted residents, including Residents #1, #3, #4, #5, #6, and #7 for the presence of PPE on their doors for quarantine precautions, found only Resident #3, and Resident #4 had PPE available outside of their room. Residents #1, #5, #6, and #7, had no PPE present if precautions were necessary in the provision of their care following recent admission/readmission. Resident #4 had no face shields present outside of the room. On 5/14/2020 at 1:15 p.m., CNA F was observed entering multiple resident rooms wearing the same soiled surgical mask he acknowledged he had worn into Resident #3's droplet precaution (isolation) room. During an interview on 5/14/2020 at 12:55 p.m., when asked about lack of face shield sanitization, the DON stated, They are supposed to be wiping those down after use. I guess those face shields should be designated for that staff member. It is not okay to not clean the face shields. The DON confirmed PPE should be donned in the order posted outside of Resident #3's room, and stated, If you are doing droplet precautions you should have a separate mask on. You should not wear it in there and then out to everyone else. 4. Review of Resident #1's Face Sheet, revealed Resident #1 was readmitted to the facility, after being hospitalized due to bacteremia (bacteria in the blood) from 4/28/2020 through 5/4/2020 at a Regional Acute Care Hospital that was treating COVID-19 positive patients. [DIAGNOSES

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) REDACTED]. Resident #1 was cognitively intact and was listed as his own Responsible Party. During an interview on 5/14/2020 at 9:55 a.m., RN A confirmed Resident #1 had been on full precautions due to quarantine following return from the hospital on [DATE]. RN A said Resident #1 had gone out to the same Regional Acute Care Hospital for a procedure on 5/8/2020, at which time he had received a negative COVID-19 test. Upon return to the facility on [DATE] Resident #1 was removed from any quarantine/precautions and remained without quarantine status. No quarantine/isolation precautions, nor any PPE were observed outside of Resident #1's room. When asked if Resident #1 could have been negative on 5/8/2020, only four days after returning to the facility - or if potential exposure to COVID-19 could have occurred on 5/8/2020 at the acute care hospital or while in transport, RN A stated, I understand exactly what you are saying (regarding continued need for quarantine). It makes a lot of sense. Review of the facility Resident Listing found new admissions and readmissions housed on three of four facility halls (some quarantined, some not quarantined). The 100 hall was designated for COVID-19 positive residents and contained no residents. Review of the facility provided New Guidance on Hospital Transfers, dated 2020, from a nationally accredited organization, revealed the following: .We strongly urge LTC (long term care) facilities to begin creating separate wings, units or floors now, by moving current residents to handle admission from the hospital and keeping current residents separate .Facilities should implement droplet precautions procedure and follow CDC guidance . On 5/14/20 at 9:39 a.m., a resident came to the doorway of the room hollering for help stating a woman was in her room rummaging through her drawers. Resident #4 was observed in that room, across the hall from her own, trying to get into the bathroom, and walking about the room. Resident #4 had a surgical mask donned around the ears and positioned below the chin, exposing the entire face. There were three staff observed in the hallway. This Surveyor approached and looked toward the Housekeeping Supervisor, (Staff) N standing nearby. Staff N went into the room and tried to direct Resident #4 out of the room. A CNA came out of another resident room to assist in redirecting Resident #4 back to her own room across the hall. Neither staff was donned with PPE. Resident #4's room had a contact/droplet precaution sign on the door with available PPE near. Staff N confirmed Resident #4 was in droplet precautions and quarantined per protocol for 14 days following admission. No one was observed to sanitize any contact surfaces Resident #4 may have touched in the other resident room. During an interview on 5/14/20 at 12:52 p.m., the DON was asked about Resident #4's precautionary quarantine, and the observation above, and responded, We're doing the best that we can with (Resident #4). The DON confirmed Resident #4 was exhibiting behaviors consistent with a [DIAGNOSES REDACTED]. The DON confirmed Resident #4 had acute supervisory needs. The DON was asked if the facility emergency staffing protocol was activated, and confirmed it was not. The DON also confirmed the dedicated unit was not used for any quarantines, and there were no residents on the unit at the time. The dedicated unit was observed to be segregated from the facility at large. According to the electronic medical record (EMR), Resident #4 was admitted on [DATE] with [DIAGNOSES REDACTED].#4, dated 5/14/20, revealed, .wandering in and out of rooms .has not slept .unable to redirect .walked up to another .and kissed them on the lips .(resident) and staff member went on a tour of the building. Resident #4's care plan, dated 5/13/20, revealed, .provide consistent care givers .to decrease confusion .at risk for isolation, depression, anxiety, and emotional burden related to pandemic .Monitor for changes in behavior (related to) changes in routine .provide supplementary activities of interest .introduce the resident to residents with similar backgrounds (5/14/20) .at risk for .COVID-19 . The care plan made no specific, resident centered reference to transmission based precautions, preferred in room activity or diversion, or how to intervene/report with behavior changes. The policy, Emergency Preparedness-COVID-19 specific Staffing in Emergencies Policy, dated 4/1/20, revealed, continue to utilize (facility acuity documents) to analyze staffing to acuity needs. This is updated during morning standup/clinical meetings . 5. On 5/14/20 at 9:46 a.m., Dietary Aide, (Staff) K was observed in the kitchen with a visibly soiled surgical mask donned to the face. The mask had black/brown spots/stains across the entirety of the mask face. When this Surveyor brought the condition of the mask to Staff K's attention, the mask was removed and observed and Staff K confirmed the mask was too soiled to wear. The following observations were made in the kitchen prep/service areas: a large pot of soup, with partially coagulated fats on the surface, with chicken and rice visible in the pot, was on the stove burner with no heat under the pot. The pot was warm to touch. There was a fry pan on the stove with two grilled ham and cheese sandwiches, still partially raw in the pan. The cheese had begun to soften and the ham and begun to dry and cook. There was no heat under the fry pan and the pan was warm to touch. There were four slices of white bread in each of the toaster spaces, and several more slices of bread sitting open on the counter. There were three corn dogs on an uncovered plate sitting atop a visibly dirty microwave oven. There was an uncovered plate of softly cooked bacon, and two uncovered bowls of tomato soup in the microwave. The microwave was not turned on, and was visibly soiled with grease and grime inside and out. There were two stainless steel third pans (steam table holding sizes) with cheesy broccoli soup filling the containers 3/4 full (about 5 inches deep), sitting on the counter, with stainless steel covers to both third pans. The pans were hot to touch on the outside. Staff K was unable to explain the food items and stated the cook and prep cook were on break. On 5/14/20 at 9:51 a.m., Cook, (Staff) L and Prep Cook, (Staff) M entered the kitchen from the service hall, with outdoor coats on. The two staff then proceeded through the entire kitchen, including the dish area, the cook and prep areas, to the office, where they removed their coats and performed hand washing. Both Staff L and M confirmed the kitchen, as observed, was in the condition they left it for break at least 30 minutes prior. Staff M confirmed the cheesy broccoli soup was being cooled on the counter. The cooling log was requested and reviewed, and did not include the soup. When asked what the temperature was of the soup when it was put on the counter, Staff L said it was not yet taken. When asked to take the temperature of the soup, Staff L retrieved a thermometer and proceeded to begin to immerse the probe into the soup when this Surveyor asked Staff L to stop and sanitize the probe prior to immersion. The soup temperature was 134.2 degrees Fahrenheit (F). When asked if the soup cooling process complied with food service safety standards, both Staff L and M agreed it did not. Staff M proceeded to put the two third pans of soup in the oven. When asked why, Staff M said she was going to reheat the soup to properly cool it down, for use later. Staff L confirmed the corn dogs were being thawed for use at lunch, and the bacon, tomato soup, white bread and grilled ham and cheese sandwiches, were all being prepared for the lunch meal. When asked if the potentially hazardous food left out at room temperature for such a duration, after partial cooking, was appropriate, both Staff L and M confirmed it was not. Staff L's face mask was hanging below the nose during the entire observation/interview. During the interview on 5/14/20 at 12:52 p.m., the DON confirmed staff had locker space available and that coats should not be worn into or through the kitchen. The Cool Down Temperature Tracking Audit, dated May 2020, received on 5/14/20 at 1:37 p.m., revealed the cheesy broccoli soup's temperature was 141 degrees F at 12:30 p.m., and a one hour temperature of 81 degrees F, at 1:30 p.m. The Certified Dietary Manager, (Staff) N, just on shift, was asked at this same time, if he was aware that the soup was already re-heated once, and replied he was not. At this time, Staff N entered the kitchen with this Surveyor, after walking through the building, including the clinical area, but did not perform hand hygiene prior to handling the soup in the kitchen. The policy Food Preparation and Service, revised 6/23/16, revealed, .Food service employees shall prepare and serve food in a manner that complies with safe food handling practices .Food preparation staff will adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness .Thawing Frozen Food .Foods will not be thawed at room temperature .The danger zone for food temperatures is between 41 degrees and 135 degrees (F). This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness .Rapid cooling .Potentially hazardous foods should be cooled rapidly. This is defined as cooling from 135 (degrees) F to 70 degrees (F) within two hours and then to a temperature of 41 (degrees) F or below within the next 4 hours .