STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235161	A. BUILDING _____ B. WING _____	04/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ASPIRUS ONTONAGON HOSPITAL, INC	601 SEVENTH STREET ONTONAGON, MI 49953

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 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 38 residents residing in the facility. This citation has six noted deficiencies: 1. The facility failed to maintain social distancing during entrance screening. 2. The facility failed to institute 14-day quarantine periods for new admissions and/or bed hold residents. 3. The facility failed to eliminate group dining to prevent transmission of COVID-19. 4. The facility failed to ensure proper Personal Protective Equipment (PPE) use to prevent transmission of COVID-19. 5. The facility failed to perform hand hygiene with PPE use. 6. The facility failed to demonstrate proper cleaning and disinfecting of environmental surfaces. Findings include: On 4/7/2020 at 10:55 a.m., during COVID-19 visitor screening Staff A was repeatedly instructed to a maintain six-foot distance from others. Facility staff and visitors were entering and exiting the facility at the same time. At no time did Staff A provide instruction to a maintain six-foot personal separation. An unidentified staff member entered the facility without social distancing, and was not screened upon entrance. When asked about social distancing by the unidentified staff member, Staff A stated, No (it was not a minimum of six-foot separation of individuals), sorry. Staff A indicated the unidentified staff member was returning from break. Review of Centers for Disease Control and Prevention (CDC), 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, p. 26, revealed the following, regarding outbreaks in healthcare settings, in part: . undiagnosed , infectious patients and visitors were important initiators of these outbreaks . During the Entrance Conference on 4/7/2020 at 11:35 a.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON)/Infection Control Practitioner confirmed Resident #1 returned to the facility from an acute care hospital and shared a room with Resident #2. The DON also noted Resident #3 was being admitted that day (4/7/2020) from an acute care hospital located in a different county where COVID-19 positive cases were present. Resident #3 would return to the same room with previous roommate, Resident #4. No separation or quarantine of newly or readmitted residents was noted by the DON. The DON confirmed group dining continued for residents who required staff dining assistance, with a maximum of 10 individuals in the dining room at a time. Review of Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes, revised 3/13/2020, pg. 5, revealed the following: Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present .where they remain for 14 days with no symptoms (instead of .returning to long-stay original room) . Review of Centers for Disease Control and Prevention (CDC), 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, pgs. 57-58, revealed the following, in part: .Single-patient rooms are always indicated for patients .who require Contact or Droplet precautions .Cohorting is the practice of grouping together patients who are .infected with the same organism to confine their care to one area and prevent contact with other patients .Cohorting has been used extensively for managing outbreaks . On 4/7/2020 at 11:52 a.m., during the main dining room lunch observation, eight residents and three staff were present. Residents were not seated with a minimum six-foot separation. During an interview at this same time, when asked if Resident #6 and Resident #7 maintained a six-foot distance, Staff F stated, I wondered about that. Staff 'F then moved Resident #7 which provided a six-foot separation. Certified Nurse Aide (CNA) D pulled her face mask down to below her chin, exposing her nose and mouth, while positioned directly next to Resident #5. CNA D walked to the sink, with the top edge of the face mask resting on her upper lip, which exposed her nose. When asked why her face mask was pulled down, CNA D responded, So I could breathe. CNA E approached with her face mask noted below her entire nose which covered only her mouth. Both CNA D and CNA E repositioned the front of their face masks with bare hands. No hand hygiene was observed by either CNA D nor CNA E after touching their masks. Review of the facility provided Isolation Procedures - Standard and Transmission Based Precautions (System), pg 3., last revised 3/2020, revealed the following, in part: Masks are to be: .Not lowered around the neck .Worn covering nose and mouth . On 4/7/2020 at 12:00 p.m., Staff H exited an unidentified resident's bathroom wearing a pair of soiled gloves, entered and exited the soiled utility room, and entered another unidentified resident's room all while wearing the same soiled gloves. When asked about cleaning and disinfecting of high-touch surface areas, Staff H stated, Well let me show you. Staff H cleared the contents off the overbed table by placing them on the bed and demonstrated use of (Brand Name) cleaning and disinfecting wipes. One wipe was retrieved to cleanse the top of the overbed table. No cleansing (wiping) of the entire center of the overbed table was observed, and reflection of light showed the entire center of the overbed table remained dry. Review of the facility provided Isolation Procedures - Standard and Transmission Based Precautions (System), pg. 3, last revised 3/2020, revealed the following, in part: Remove gloves: .Promptly after each use .Before touching non-contaminated items and environmental surfaces . Prior to exiting the patient's room . Perform Hand Hygiene immediately after removing gloves . Page 6 of this same document detailed: .Disinfectant wipes may be used to decontaminate small surfaces or items. Allow disinfectant to remain wet on surface for the time stated on the label to be effective . On 4/7/2020 at 12:30 p.m., when asked who participated in group dining, the DON stated, It was up to 10 people including staff. The DON confirmed residents were to be seated with a minimum distance of six feet of separation. When asked about proper mask usage by staff, the DON stated, Staff should have their nose covered .Absolutely they should have their mouth covered . The NHA confirmed no competencies had been completed regarding face mask usage. Regarding environmental cleaning, the DON stated, They should be wiping the whole tabletop.

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