STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235601	A. BUILDING _____ B. WING _____	05/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IRON RIVER CARE CENTER	330 LINCOLN AVE IRON RIVER, MI 49935

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 maintain adequate infection control practices during a COVID-19 Infection Control Survey. This deficient practice resulted in the potential for the transmission of COVID-19 (a highly transmissible [MEDICAL CONDITION] infection), which has the potential to affect all 50 residents in the facility. This citation has eight noted deficiencies: 1. Failure to follow the Centers for Disease Control (CDC) guidance for social distancing (at least 6') during the employee screening process. 2. Failure to complete infection surveillance in near 'real-time' (data received with no noticeable delay) during April, 2020, and May, 2020. 3. Failure to contact the local health department regarding a cluster of residents with respiratory infections of unknown origin, in April 2020. 4. Failure to provide consistent staffing (the assignment of staff to certain residents), given the COVID-19 pandemic and CDC healthcare guidelines. 5. Failure to complete 'contact tracing' (tracing the resident contacts of a potentially COVID-19 infected employee(s) to prevent or minimize transmission). 6. Failure to perform proper hand hygiene when performing resident incontinence care for one Resident (#101). 7. Failure to obtain temperatures on residents every eight hours, as ordered by the physician for four of nine Residents (#102, #103, #104, #105) reviewed for symptom monitoring. 8. Failure to perform CDC recommended isolation precautions for one Resident (#106) of five residents reviewed for respiratory infections, including the potential for a COVID-19 diagnosis. Findings include: (All survey times are reflected in Eastern Daylight Time.) On 5/05/20, beginning at 2:53 p.m., Surveyors observed the afternoon shift Certified Nurse Aides (CNAs) arriving to the resident care area, stopping at the central nurse's station area to complete the required employee screening. These employees, including CNA E, CNA F, CNA G, CNA J, and CNA K, were observed standing 1'-2' apart. The employees were gathered together behind the nurse's station counter, quickly taking their temperatures and passing the thermometers between them. The employees sanitized the thermometers, demonstrated appropriate hand hygiene, and placed a new protective sleeve on the oral thermometer before taking their temperatures. As additional employees arrived, they gathered in the same area as the CNAs previously checked in had gathered. An afternoon nurse, Licensed Practical Nurse (LPN) I, was seated at the nurses station, about 6' away from the CNAs, while the employee screening was occurring. After each employee took their temperature and logged it in the employee screening log, they answered the employee/visitor COVID-19 questions, reviewed their assignments, and began their shift. Employees did wear masks upon arrival to the nurse's station, but some removed them to have their temperatures taken orally. The employee screening area was only at the central nurse's station, which was located at the beginning of the three resident halls. Residents were observed in close proximity (at times within 6') to the nurse's station during these observations, as there was no physical separation from the nurse's station to the resident halls. The employees entered the nurse's station/ resident care area from a door which connected to the back-employee entrance. There was a hand sanitizer station stand at the back entrance, with a sign directing the employees to proceed down the back hall to check themselves in at the nurse's station. This hallway passed by the laundry room, kitchen, and the employee break room. The observations of the screening area were completed by 3:10 p.m. During an interview on 5/05/20 at 3:15 p.m., LPN I was asked about the employees gathering less than 6 feet apart at the nurse's station. LPN I stated, Yes, I did (observe this). I did say something to them . I don't want it (COVID-19) here. They have been told a number of times. They should be spaced down the hall, waiting. We talk to them a lot .that is why the break room is broke up (separated). We can only have four in there (the break room) at a time . LPN I confirmed the employees usually go to the nurse's station first, but they may stop in the break room and drop off their lunch, before getting checked in at the nurse's station. During an interview on 5/05/20 at 3:35 p.m., CNA E was asked about the lack of social distancing observed at the nurse's station. CNA E responded, It (the distance) should be 6' apart .we should take turns. We were less than 6' apart .Everything is a learning lesson . During an interview on 5/05/20 at 3:40 p.m., CNA G was asked the same question, and responded, Yes, it was a big mess today. We were all in the same space. There was a big cluster of people there. That (lack of social distancing at the nurse's station) is fairly normal . CNA G confirmed she was using her personal thermometer to take her temperature, which they share with other employees, stating, We don't have good equipment. I had to buy my own. During an interview on 5/05/20 at 4:28 p.m., the Infection Preventionist nurse, LPN B, was asked about the lack of appropriate social distancing observed at the nurse's station, and if any education was done with staff regarding social distancing, per the CDC guidelines. LPN B responded, Everybody should just be 6' apart. We all pretty much educate each other. Me personally, no, I have not provided an education on this . When asked if the staff should be going into the break room before being screened at the nurse's station. LPN B stated, This is the first I heard of it. Staff should be coming to the nurse's station .That is not a perfect system right now . When asked about how many thermometers were in the facility, LPN B reported there were three thermometers, which was subsequently confirmed by Surveyor observations with LPN I. LPN I reported there was no thermometer shortage, but a facility temporal thermometer was recently not working, and the facility was addressing this. The Nursing Home Administrator (NHA) later provided an order slip showing three non-contact Infrared forehead thermometers were ordered on [DATE], with arrival projected on 5/07/20. A review of the document, Employee Screenings, dated 3/2020, provided by the NHA on 5/05/20, revealed, Employees of (the facility) must be screened when coming into the facility until further notice, due to COVID-19. All employees will be screened at the Nurses station. Must wear mask when you enter the facility . During an interview on 5/05/20 at 4:28 p.m., LPN B was asked for the facility Infection Surveillance documents, including the line listings and mapping, facility tracking of resident and also staff infections, for March 2020 through the current date. This documentation had been requested from the NHA during the entrance conference on 5/05/20 at 1:15-1:20 p.m., which had not yet been received. LPN B reported earlier months were complete (January, February, and March, 2020), and LPN B was 'working on April's', and the first days of May documentation was not done, and added, It (the April and May documentation) will be done absolutely by today. I am just finishing April now . During an interview on 5/05/20 at 5:20 p.m., the Nursing Home Administrator (NHA) acknowledged this data was not completed (for April and May 2020), and reported they were having LPN B stay late to complete it. The NHA reported they would email the Surveyors this data once it was completed. The Surveyors exited the facility on 5/05/20 at 5:45 p.m., without any infection surveillance documentation/data. Emails were later received by the Surveyors on 5/05/20 at 6:08 p.m. and 7:14 p.m., containing the infection control surveillance reports and documentation, including line listings and mapping for residents and staff for February, March, and April, 2020. Line listings were received for May 2020 for resident and staff infections thus far this month. A review of the April 2020 resident line listing and mapping revealed eight infections/(seven) residents, with respiratory infections. The review revealed a cluster of these residents resided down the 200 hall (wing). It was not evident from the logs if any of the eight residents were placed on isolation precautions. These infections were treated with antibiotics and documented as resolved in April 2020. A review of the April 2020 employee infection line listing revealed 20 employees reported symptoms of illness. Of the 20 employee illnesses, at least 9 of the employees reported potential COVID-19 symptoms, including fever, cough, sore throat, possible COVID-19 exposure, and/or 'flu-like' symptoms. It was noted the employee line listing only contained the employee

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.

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F 0880

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Many

(continued... from page 1)

names, an unspecified date, and symptoms of illness. It did not contain date infection cleared, when the employee returned to work, or if COVID-19 testing was completed. The May line listing for one employee, CNA N, showed the employee reported COVID-19 symptoms on 5/03/20, and was COVID-19 tested on [DATE]. The documentation did not indicate whether any contact tracing had been completed to determine potential resident exposure. During an phone interview with the NHA and the interim/acting Director of Nursing (DON) on 5/06/20 at 9:41 a.m., the NHA was asked about the eight resident respiratory infections, if the residents were placed on transmission-based precautions, and if any of these residents were tested for COVID-19. The NHA conveyed these residents were not placed on transmission-based precautions because there were no private rooms available, as the potential isolation rooms on the 300 wing were occupied or unavailable in April 2020. The NHA stated that those rooms were being used by Medicare-A short term rehabilitation residents, managed care residents, or private pay residents, and reviewed each room (on the 300 (isolation designated) hall), explaining why they were unavailable. The NHA explained that these residents were not tested for COVID-19, or isolated, and that the facility physician/medical director and the facility nurse practitioner saw these residents. The NHA was asked about any contact tracing (tracking of employee to resident contacts) for the employee who was COVID tested on [DATE]. The NHA explained this employee, CNA N, worked down the 200 hall with a partner, and no contact tracing was completed, stating, We called him (on 5/03/20) and set up testing .We didn't isolate the residents he worked with. The NHA stated CNA N last worked on 4/29/20, was tracked by the NHA, and called off on 5/03/29 reporting symptoms of COVID-19. The facility referred CNA N for testing on 5/04/20. (The facility provided documentation on 5/06/20 showing the results received 5/05/20 were negative for COVID-19.) Review of the April 2020 line listing documented 8 residents with respiratory infections. Some of these residents resided on the 200 wing, where the mapping showed five respiratory infections. Review of the Resident COVID Tracking Tool for April 2020 showed two residents listed on the COVID-19 tracking log, also with respiratory infection symptoms. These two residents were COVID tested , and the results were negative. This would increase the total residents with respiratory infections in April 2020 to 10 residents, not the eight that were noted on the April 2020 line listing. Review of the facility document, Infection Report: Monthly Accumulation of Data, Month of April, 2020 revealed, Respiratory Infections: 8, emailed to Surveyors by the NHA on 5/05/20. During the aforementioned 5/06/20 phone interview, the NHA was asked if there were indeed 10 residents in April 2020 with respiratory infections. The NHA acknowledged the discrepancy in documentation, confirmed there were 10 residents with respiratory infections, and conveyed plans to educate LPN B to include Residents on the COVID tracking log on her Infection Control paperwork. The NHA reported the April and May 2020 Infection Control data was not complete because, It was a switchover from (the former Director of Nursing (DON)) and (LPN B) taking over .It (the surveillance data) was halfway done. It was a learning experience. We are going to revamp how things are done. I am aware of the need to have it (the infection surveillance data) in real-time, and it (the process) will be ten times better now . The NHA stated the former DON had left her position April 30th, and LPN B was new to her position. During an interview in the facility on 5/06/20 at 1:00 p.m., the NHA was asked about the employee line listings not showing when the symptoms were resolved, when the employees were cleared to return to work, and if any COVID testing was done. The NHA acknowledged their surveillance log did not show complete, necessary data, and added, I need to sit down with (LPN B) about that. Our consultant is going to be sitting down doing trainings with (LPN B) to be trained the right way. The NHA also acknowledged the need for an alternate employee infection line listing form. The NHA next reviewed the employees with COVID-19 symptoms, and revealed additional documentation regarding the employee absences. The Employee Illness Tracking Log, a second employee log, with a handwritten date of April 2020, revealed there were four employees tested for COVID, and all tested negative. This interview and related additional documentation by the NHA revealed no employees were COVID (+), including these four employees and CNA N, who was tested in May 2020. The NHA earlier acknowledged there was no contact tracing done by the facility. During this same interview, the NHA was asked about consistent staffing (the assignment of staff to the same residents to potentially limit transmission), given the COVID pandemic and CDC guidelines. The NHA stated some aides work back and forth between halls so they will know how to take care of the all the residents, indicating the staff did not work consistently on the same halls. During an interview on 5/06/20 at 2:45 p.m., the NHA was asked for evidence of any coordination with the health department in April of 2020, related to the cluster of residents with respiratory infections noted on the April line listing and mapping, and the COVID tracking log. The NHA reported the former DON did not talk to the health department about any clusters of respiratory infections. During an interview with the NHA on 5/06/20 at 3:49 p.m., the NHA was asked for a plan if the facility receives a COVID (+) resident. The NHA indicated the facility currently has the space available to place residents in isolation if needed. The NHA was asked if they were aware of the CDC and State updates on COVID-19 best practices and frequently updated guidelines. The NHA reported they were aware of these guidelines. Review of the facility policy titled, Infection Prevention and Control Program, revised 3/2020, revealed, .Prevention of Infection .Identifying possible infections or potential complications of existing infections .Educating staff and ensuring they adhere to proper techniques and procedures .following general and disease-specific guidelines such as those from the Centers for Disease Control (CDC) . Review of the CDC document, Social Distancing, revealed, Limiting face to face contact with others is the best way to slow the spread .To practice social or physical distancing, stay at least 6' (about 2 arms length) from other people .In addition .keeping space between you and others is one of the best tools we have to avoid being exposed to this virus, and slowing its spread locally and across the country and world. Limit close contact with others outside your household in indoor and outdoor spaces. Since people can spread [MEDICAL CONDITION] before they know they are sick, it is important to stay away from others when possible, even if you-or they-have no symptoms. Social distancing is especially important for people who are at higher risk for severe illness from COVID-19 . Review of the facility policy titled, Surveillance for Infections, revised 3/2020, provided by the NHA on 5/05/20, revealed, .(The) Infection Preventionist or designated Infection Control person is responsible for gathering and interpreting surveillance data . Review of the facility policy Infection Preventionist, revised 3/2020, provided by the NHA on 5/05/20, included a job description which stated, .Administrative Functions .Maintain a written record of all residents and employees with community or healthcare associated infections . Review of the CDC document, Public Health Surveillance: Preparing for the future, dated September, 2018, revealed, .Near-real-time data allows users to quickly detect and monitor health impacts in their local communities . Review of the (State) Department of Health and Human Services document, Guidance to Protect Residents of Long-Term Care Facilities, dated 4/09/20, revealed, .Notify the local health department immediately (<24 hours) for : .clusters (3 (or more) residents and/or HCP (health care practitioner) of respiratory infection .Long-term care facilities should exercise as best as possible consistent (staff) assignment: Consistent assignment (meaning the assignment of staff to certain residents) for all residents regardless of symptoms or COVID-19 status. This can enhance staff's familiarity with their assigned residents, helping them detect emerging condition changes that unfamiliar staff may not notice. The goal is to decrease the number of different staff interacting with each resident as well as the number of times those staff interact with the resident. Also, staff as much as possible should not work across units or floors .If a healthcare worker worked while symptomatic with symptoms consistent with COVID-19 .Prioritize the symptomatic healthcare worker for COVID-19 testing. Residents that were cared for by the healthcare worker while symptomatic should be: Restricted to their room, monitored for fever and respiratory symptoms at least daily, required to wear face masks if leaving their room, and cared for using recommended PPE until results of the healthcare worker's testing are known .

6. A review of Resident #101's medical record revealed medical [DIAGNOSES REDACTED]. Resident #101 was admitted to the facility on [DATE]. On 05/05/20 at 2:00 p.m., bowel incontinence care provided by CNA L and CNA H for Resident #101 was observed. CNA L was observed assisting with the removal of the soiled brief and placing it in the garbage can. CNA H was observed wearing gloves to remove Resident #101's soiled brief and cleanse the peri area. CNA H and CNA L then placed a clean brief on Resident #101 and pulled up Resident #101's underwear and pants. Neither CNA removed their soiled gloves and performed hand washing after touching the soiled brief and before Resident #101's clean brief was applied. During an interview on 05/05/20 at 2:09 p.m., CNA H was asked about the process for hand washing when performing incontinence care on residents. CNA H reported they wash their hands before and after providing care but not when moving to a soiled area to a clean area. CNA H stated, Now that you say that, it makes sense that you should (wash your hands). On 05/05/20 at 2:17 p.m., CNA L was asked about hand washing when performing incontinence care. CNA L reported they wash their hands prior to providing care and again when it is finished. CNA L did not think it was necessary to wash their hands during incontinence care due to the use of washcloths which provided a barrier and prevented contact with stool or urine. During an interview with the DON on 05/05/20 at 4:28 p.m., the DON reported the expectations pertaining to hand washing during incontinence care were to wash hands before starting, after completing, and before moving to a clean area. The DON replied If hands aren't washed when going from a dirty area to a clean area, you're just taking the dirty to the clean area. When the observation during Resident #101's incontinence care were shared, the DON stated, I am appalled. The DON replied there obviously needed to be more education on handwashing. A review of the facility's Morning and Evening Care policies and procedures dated 6/17 did not reveal any information pertaining to hand washing during incontinence care. The facility's educational material pertaining to hand washing did not include any information pertaining to hand washing when performing incontinence care. A hand washing policy was not provided. The CDC provided the following guidelines, The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following recommendations for hand hygiene in healthcare settings: Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) following clinical indications: .Before moving from work on a soiled body site to a clean body site on the same patient .After contact with blood, body fluids, or contaminated surfaces. (retrieved on 05/07/20 from https://www.cdc.gov/handhygiene/providers/guideline.html). 7. During an interview on 05/05/20 at 3:39 p.m., the DON reported part of the process for screening existing residents was to take their temperatures three times a day. On 5/5/20 at 3:45 p.m., Resident # 102, Resident #103, Resident #104, and Resident #105's medical records were reviewed and revealed the following: Resident #102: a temperature log which showed Resident #102's temperature had been taken two times daily on 4/30/20, 5/3/20, and 5/4/20. Resident #102 had not had their temperature taken since 5/4/20 at 10:30 p.m. Resident #103: a temperature log which showed Resident #103's temperature had been taken two times daily on 5/3/20. Resident #103 had not had their temperature taken since 5/4/20 at 10:30 p.m. Resident #104: a temperature log which showed Resident #104's temperature had been taken two times daily on 4/30/20 and 5/2/20. Resident #104 had not had their temperature taken since 5/4/20 at 10:00 p.m. Resident #105: a temperature log which showed Resident #105's temperature had been taken two times daily on 5/3/20. Resident #105 had not had their temperature taken since 5/4/20 at 10:00 p.m. On 5/5/20 at 4:00 p.m., CNA F was asked if there were any additional locations in the medical records where resident temperatures may be documented. CNA Fstated, If it isn't there (on the temperature logs) it (temperature check) wasn't done. CNA F was unable to voice why the resident temperatures had not been taken three times a day and reported temperatures were supposed to be taken three times daily. On 5/5/20 at 4:28 p.m., the DON verified resident temperatures were supposed to be taken three times a day. When findings were shared regarding the residents' missing temperatures, the DON replied the temperatures should have been taken. On 5/5/20 at 5:30 p.m., a copy of the resident screening policy supporting resident temperatures were to be taken three times a day was requested from the NHA. The NHA reported it wasn't actually the policy, but it was what Medical Director/ Physician M had directed staff to do because it was best practice. 8. During an interview with the DON on 05/05/20 at 4:39 p.m., the DON was asked about the process for accommodating new residents who needed to be quarantined and current residents who developed symptoms of COVID-19. The DON reported they were trying to do this, but it was difficult due to the lack of space in the facility. During a review of the facility's April infection control information, Resident #106 was identified as having a lower respiratory infection. A review of Resident #106's medical record revealed Resident #106 was admitted to the facility on [DATE]. Resident #106 had medical [DIAGNOSES REDACTED]. Neither chronic nor acute respiratory conditions were documented in Resident #106's medical diagnoses. A nurse note written on 4/16/20 at 1700 (5:00 p.m.) revealed the following information, Resident shaking (whole body)-Temp up to 101.5, ([MEDICATION NAME]) 650 mg suppository given. (Physician M) was notified ordered labs (blood draws) and [MEDICATION NAME] (antibiotic). An additional nurse note written 4/17/20 at 11:30 a.m. revealed the following information, Seen by (Physician M') today- spiked a fever last evening 101.5. and again this a.m. (morning) 101.3 orally. Scattered rales (abnormal lung sounds) in upper and lower R (right) lung fields. WBC (white blood cells) today increased 28.5, UA (urine specimen) clear (no urinary tract infection) .Started on [MEDICATION NAME] last evening but today we're adding a 10 day course of [MEDICATION NAME] (an antibiotic) to better cover this respiratory issue and elevated WBC . an order written [REDACTED].portable CXR (chest x-ray) congestion, cough. During an interview on 05/06/20 at 3:00 p.m., Physician M was asked about the number of residents with respiratory infections in April. Physician M reported COVID-19 testing had not been being performed on residents due to lack of test availability and delayed results in the area. When asked if there was a process in place for moving residents with COVID-19 symptoms to an isolation room, Physician M replied the residents with COVID-19 symptoms should be placed in isolation, but the facility did not have the ability to do this due to lack of available room. Physician M reported Resident #106 had a history of [REDACTED].#106 had not been tested for COVID- 19 due to limited availability of testing and delayed results. Physician M did not think Resident #106 had been moved to an isolation room. Physician M reported they spend so much time with the residents, they knew when respiratory illnesses were chronic versus acute. Physician M stated COVID-19 was a new thing they would have to start considering, and stated they would have to step it up with ordering COVID-19 testing and considering placing symptomatic residents in isolation. Physician M stated, We need to change the [MEDICATION NAME] a little bit. A review of the facility's COVID-19 Policy (undated) revealed the following information: Procedures . Ensure rapid, safe triage of isolation of residents with suspected COVID -19 symptoms or other respiratory infection (e.g. cough, fever) . we will evaluate all new fevers and respiratory illnesses among existing and new residents . continued vigilance for prompt detection, triage, and isolation of potentially infectious residents on an ongoing basis .