

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 235381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/13/2020
NAME OF PROVIDER OF SUPPLIER CHIPPEWA COUNTY WAR MEM HOSP LTCU		STREET ADDRESS, CITY, STATE, ZIP 500 OSBORN BLVD SAULT SAINTE MARIE, MI 49783	
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	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on observation, interview, and record review, the facility failed to maintain infection control practices during a COVID-19 Focused Infection Control Survey. This deficient practice resulted in the potential for transmission of COVID-19 and other communicable diseases which had the potential to affect all 50 residents residing in the facility. This deficient practice has two noted deficiencies: 1. Failure to perform adequate COVID-19 visitor entrance screening. 2. Failure to complete infection control surveillance for employee illnesses. Findings include: On 5/12/2020 at 12:35 p.m., this Surveyor completed the COVID-19 visitor screening through the main hospital entrance performed by Staff O. After being asked for my name and phone number, Staff O said, Do you have a fever, cough, sore throat or anything like it? Staff O had not ask any additional questions related to contact with potentially ill household members nor potential contact with positive COVID-19 individuals. Staff O had not performed any hand hygiene prior to obtaining Surveyor's tympanic temperature and did not instruct this Surveyor to perform hand hygiene. Staff O instructed this Surveyor to place a sticker on myself which read, TUESDAY I have been screened 5/12. Staff O had not provided any visitor education (verbally nor in writing). Review of facility provided, COVID-19 HOSPITAL SCREENER ALGORITHM (updated 5/4/2020 at 12:00 p.m.) read in part, 2. Have you had any cough, shortness of breath or difficulty breathing or at least 2 of the following symptoms: fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell? 3. Are any members of your household sick with the symptoms listed above? 4. Have you have (sic) any contact with someone with a confirmed [DIAGNOSES REDACTED].? Review of CMS (Centers for Medicare & Medicaid Services) Memorandum Summary, 3-23-2020, Reference: QSO-20-20-All, page 7, read in part, Limitation on Visitors .encourage frequent hand washing and use of hand sanitizer before entering the facility and before and after entering patient rooms .should screen and limit visitors .as well as close contact with a suspect or laboratory-confirmed COVID-19 patient within the last 14 days .Facilities should instruct visitors to limit their movement within the facility . Review of facility provided, SCREENER ASSIGNMENT INSTRUCTIONS: updated 4/27/20, read in part, .Use screening questions on algorithm .make sure when you hand sanitize that the patient sees you do it: as well as have them use it . During an interview on 5/12/2020 at 1:55 p.m., when asked about visitor screener process for COVID-19, the Nursing Home Administer (NHA), Director of Nursing (DON), and Quality Director (Staff) A all confirmed additional screening questioning were warranted during this Surveyor's screening process which were provided on the screening algorithm but not reviewed. During the same interview on 5/12/2020 at 1:55 p.m., the DON was asked to provide employee illness data (sick calls) for review. The DON indicated there was no available data for the last seven months. After discussion for the potential exposure risk of communicable illnesses from staff to the residents, the DON responded, Oh, I absolutely understand (the need for tracking staff illnesses). Review of facility's IFC (Infection Control)-Surveillance updated 6/18, read in part, To identify nosocomial (facility acquired) and community acquired infections. To identify sources, trends of infections, care delivery systems, treatments, medications, or work practices that impact patient care .Make sure that protection of residents, healthcare workers, visitors and others are being prevented and improved .Identification of potential problems that will lead to fewer infections .</p>		

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.