

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/09/2025
NAME OF PROVIDER OR SUPPLIER  Schoolcraft Medical Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE  520 Main St Manistique, MI 49854	

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)
<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>49735</p> <p>Based on interview and record review, the facility failed to report Payroll Based Journal (PBJ) information to CMS (Centers for Medicare and Medicaid Services). This deficient practice resulted in inaccurate reporting of staffing levels with the potential to affect all 53 residents.</p> <p>Findings include:</p> <p>Review of CMS PBJ Staffing Data Report FY (fiscal year) Quarter 4 2024 (July 1 -September 30) revealed the metric No RN (Registered Nurse) Hours, Excessively Low Weekend Staffing, One Star Staffing Rating, and Failed to have Licensed Nursing Coverage 24 Hours/Day Triggered with the following infraction dates being: No RN hours every day beginning with 7/1/24 through 9/30/24. Failed to have Licensed Nursing Coverage 24/Hours/Day every day beginning with 7/1/24 through 9/30/24</p> <p>During an interview on 1/9/25 at 9:59 a.m., Human Resource Manager F stated, I input the information for the PBJ report . we switched companies to take our data and convert it and send it to CMS .we did find out that it did not work.</p> <p>During an interview on 1/9/25 at 10:27 a.m., Nursing Home Administrator (NHA) stated, the report was not created correctly., acknowledging the report was not submitted correctly.</p> <p>Facility policy for PBJ reporting was requested from facility but was not given prior to exit.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49735</p> <p>Based on observation, interview, and record review, the facility failed to implement a comprehensive infection control program to mitigate the spread of Norovirus during an outbreak by failure to:</p> <ol style="list-style-type: none"> <li>1. Implement effective disinfection of the facility.</li> <li>2. Perform outbreak surveillance to track and mitigate the spread of Norovirus.</li> <li>3. Adhere to Hand Hygiene Infection Control Principles.</li> </ol> <p>This deficient practice resulted in a sustained outbreak affecting 18 Residents out of a total facility census of 63 residents who contracted Norovirus. Residents (R26 and R44) were hospitalized from the outbreak. The failure to mitigate the outbreak also resulted in identification of sustained transmission of Norovirus with two additional Residents confirmed by facility staff who tested positive on 1/8/25.</p> <p>Findings include:</p> <p>On 1/1/25, three Residents (#8, #44, &amp; #250), developed symptoms of emesis (vomiting) and diarrhea. Resident #44 (R44) was sent to the hospital on 1/2/25 and was confirmed positive for Norovirus infection and was subsequently admitted to the hospital. The Infection Preventionist (IP)/Registered Nurse (RN) A provided a handwritten note which indicated Resident #26 (R26) developed symptoms of Norovirus on 1/6/25, including diarrhea and vital signs very unstable and was sent to the Emergency Department. R26 was also admitted to the hospital and was admitted with Pneumonia and was on contact precautions at the hospital due to the diarrhea. Testing had not been performed for Norovirus according to the hospital.</p> <p>On 1/7/25 at approximately 1:30 p.m., an unidentified housekeeper was observed in the east hallway wiping down the handrails. This staff member stated to not to lean on the handrails because they were wiping them down with bleach. The unidentified housekeeper then gestured to the white cloth in her hand. This Surveyor observed the cloth and noted it was not completely saturated. The unidentified staff member continued down the hall wiping down the handrails with the same damp cloth.</p> <p>On 1/7/25 at approximately 3:00 p.m., Housekeeping Aide/Staff E stated the facility used bleach water to clean and disinfect using one cup of bleach to every gallon of water. Staff E stated their supervisor told them to use the bleach water to clean high touch areas twice a day.</p> <p>During an interview on 1/8/25 at 10:09 a.m., the Director of Nursing (DON) stated there were two additional cases of resident illnesses consistent with Norovirus today, and confirmed there were currently two residents hospitalized with Norovirus .</p> <p>The facility was asked to provide their surveillance of the outbreak. RN A provided the survey team with a typed summary of events from the outbreak on 1/8/24. However, there was no additional information on education provided, auditing, or monitoring of the outbreak to mitigate the spread.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/8/25 at approximately 10:12 a.m., during an interview, RN A stated, The Norovirus started with two Residents on the South wing and one Resident on the [NAME] wing . we were encouraging residents to stay in their rooms . the Norovirus then jumped to the Northeast wing . our team decided not to close down dining or activities . if residents are not symptomatic and their roommate is sick the resident without symptoms can come out for dining . we have 17 residents with the Norovirus currently .</p> <p>RN A was asked to provide their surveillance of the outbreak and any efforts to mitigate the spread.</p> <p>During an interview on 1/8/25 at 11:41 a.m., the NHA stated, We are still having communal dining .I feel that closing dining would not change anything (won't assist in stopping the spread of Norovirus) .</p> <p>During an interview on 1/8/25 at 12:18 p.m., Licensed Practical Nurse (LPN) B stated, I didn't know we could not use hand sanitizer for the Norovirus .it is what I have been using .</p> <p>Review of facility document titled GI Outbreak January 2025, read in part . Wash hands with soap and water as hand sanitizer does not kill the Norovirus .</p> <p>During an interview on 1/8/25 at 12:31 p.m., Housekeeping Supervisor/Staff C stated, We are using bleach to clean due to the Norovirus .we are using a 1 to 10 ratio .bleach to water .we did get a special cleaner to use that would kill the Norovirus but .we decided not to use it .the bleach has a three minute contact time (how long the surface needs to remain visibly wet in order for the disinfectant to be fully effective) .I looked to the CDC website .I educated the housekeeping staff how to use the bleach on the 6th of January .</p> <p>On 1/8/25 at 12:41 p.m., Housekeeping Aide D stated, We use a 1 to 10 ratio (bleach to water) to clean .1 cup of bleach to 10 cups of water and clean high touch areas three times a shift and wring out the cleaning rags so they aren't dripping wet .</p> <p>On 1/8/24 at 11:22 a.m., Supervisor C stated, We went to a spray that kills in one minute . but when we are spraying it on, we felt it didn't cover everything we would like it to cover as it was a spray . that product worked in one-minute.</p> <p>On 1/9/25 at 12:28 p.m., Supervisor C stated this was why they went to a bleach solution because the staff weren't sure of the effectiveness of the spray and didn't like to use it.</p> <p>During a follow-up interview on 1/8/25 at 1:02 p.m., Supervisor C acknowledged the housekeeping staff were not waiting for three minutes to ensure proper contact time of the bleach solution to the surfaces. Supervisor C indicated staff felt pressure from too many other job duties. Indicating staff would only wipe down surfaces, then move on to other job duties and would not leave surface completely wet for the correct time frame.</p> <p>On 1/8/25 at 3:00 p.m., Resident #64 (R64), who was identified as having Norovirus was observed sitting in her wheelchair in the East hallway. R64 attempted to grab this Surveyor's hand while self-propelling. There was no staff noted in the hallway at the time to redirect R64 back to her room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a follow-up interview on 1/8/24 at 4:06 p.m., RN A acknowledged the facility had 18 residents with Norovirus, two of which were identified during this annual survey, demonstrating the facility was experiencing a sustained outbreak of Norovirus.</p> <p>Review of CDC website on 1/13/25 at 8:41 a.m., titled Norovirus: Explore Topics subtitled: How to Prevent Norovirus .Clean and Disinfect Surfaces, 11/1/24, read in part . Leave bleach disinfectant on the affected area for at least 5 minutes .</p> <p>Review of the CDC website on 1/13/25 at 8:43 a.m., titled Norovirus: Explore Topics subtitled Norovirus Prevention Steps and Strategies, last updated 11/1/24, read in part . clean and disinfect surfaces after someone vomits or has diarrhea .disinfect the area as directed on the product label .</p> <p>Review of facility housekeeping policies found no instructions on how to appropriately disinfect or clean nonporous surfaces using a bleach solution in response to an outbreak of an infectious disease. None of the policies specified surfaces had to remain wet for a minimum contact time as described in the guidance from the CDC in response to mitigating an outbreak of Norovirus.</p> <p>On 1/8/24 at approximately 3:45 p.m., the NHA stated the facility did not stop communal dining or activities during the active outbreak. The NHA did acknowledge Norovirus spreads thru direct contact with the organism from an infected person.</p> <p>Review of facility policy titled Infection Outbreak Response and Investigation last reviewed/revised 3/5/24, read in part . Implementation of infection control measures .staff will be educated on the mode of transmission of the organism, symptoms of infection and isolation or other special procedures this includes special environmental infection control measures that are warranted based on the organism and current CDC guidelines .</p> <p>During a follow up interview on 1/8/25 at 4:06 p.m., RN A acknowledged the outbreak was not posted at the entrance of the facility. RN A stated they did not know how the facility was being disinfected and was not monitoring this activity for staff adherence to proper infection control practices and/or cleaning/disinfection.</p> <p>Review of facility policy titled Infection Prevention and Control Program, last reviewed 1/2/25, read in part . An infection prevention and control program is designed .to help prevent the development and transmission of communicable diseases and infections .the infection preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases .a system of surveillance is utilized for prevention, identifying, reporting, investigation, and controlling infections and communicable diseases .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility document titled Infection Preventionist Job Description read in part . Major duties and responsibilities . develops and implements an ongoing infection prevention and control program to prevent, recognize and control the onset and spread of infections .establishes facility wide systems for the prevention, identification, reporting, investigation and control of infections an communicable diseases of residents . overseas resident care activities that increase risk of infection .provides education related to infection prevention and control principles, policies, and procedures to staff, residents and families .collaborates with other departments in fulfilling requirements in relation to occupational health and safety .develops, schedules and directs refresh training as necessary for all personnel .serves as a resource for staff regarding infection prevention and control, including the identification of when a resident needs to be place on transmission based precautions .works with environmental services to prevent cross contamination in the care environment .helps to prevent transmission of infection during care.</p> <p>Review of facility policy titled Isolation Precautions last reviewed 4/2/21, read in part .It is our policy to take appropriate precautions, including isolation, to prevent transmission of infectious agents .transmission based precaution refers to the actions .that are based upon the means of transmission (airborne, contact, and droplet) in order to prevent or control infections .contact precautions are measures that are intended to prevent the transmission of infectious agents .which are spread by direct or indirect contact with the resident or the residents environment .</p> <p>Review of facility policy titled Infection Outbreak Response and Investigation last reviewed 1/2/25, read in part .The facility promptly responds to outbreaks of infectious diseases within the facility to stop transmission and prevent additional infections .outbreak refers to the occurrence of more cases of a communicable disease than expected in a given area or among a specific group of people over a particular period of time . recognition of outbreak . a sudden cluster of infections .during a short period of time i.e. three or more cases .</p> <p>Review of Centers for Disease Control and Prevention (CDC) website on 1/13/25 at 8:40 a.m., titled, Norovirus: Explore Topics subtitled Norovirus Prevention Steps and Strategies, last updated 11/1/24, read in part . Wash your hands often with soap and water, hand sanitizer alone does not work well against Norovirus .</p> <p>Review of facility policy titled Hand Hygiene, last reviewed 1/9/25, read in part . Staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors .hand hygiene .soap and water .after caring for a person with known or suspected infectious diarrhea .</p> <p>Review of CDC website on 1/13/25 at 8:48 a.m., titled Norovirus: Explore Topics subtitled How Norovirus Spreads last updated 4/24/24, read in part . Norovirus is very contagious .you can get Norovirus by accidentally getting tiny particles of feces or vomit in your mouth from a person infected with Norovirus . Norovirus spreads through sick people and contaminated surfaces when a person with Norovirus touches surfaces with their bare hands .tiny drops of vomit from a person with Norovirus spray through the air landing on surfaces or entering another person's mouth, or a person with Norovirus has diarrhea that splatters onto surfaces .</p> <p>35103</p> <p>3. Appropriate Performance of Hand Hygiene</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/9/25 at approximately 9:00 a.m., RN G administered Azelastine Hydrochloride nasal spray, two puffs, into each nostril of Resident #12 (R12) without the performance of hand hygiene or donning of gloves.</p> <p>On 1/9/25 at approximately 9:05 a.m., RN G was observed as they examined R12's open, what appeared to be a scratched area on their posterior, upper hip. RN G explained the scratched area was new and RN G said she was going to apply barrier cream to the open, scratched skin area. RN G applied barrier cream to R12's open wound without performance of hand hygiene or donning of gloves.</p> <p>On 1/9/25 at approximately 9:07 a.m., RN G was observed as they applied a 4% Lidocaine Transdermal Patch to R12's posterior, right hip. RN G did not don gloves prior to application of the patch to R12's skin. RN G's bare hands were observed to touch R12's bare posterior hip as the patch was smoothed out over the Resident's skin. No hand hygiene was performed after the patch application. RN G then assisted with repositioning R12 in bed, tied up the open garbage bag near the sink and rearranged the linens on R12's bed. No hand hygiene was performed.</p> <p>On 1/9/25 at approximately 9:09 a.m., RN G was observed as they administered Fluticasone Propionate nasal spray, one puff in each nostril without the performance of hand hygiene before or after administration of the nasal spray. RN G held the nasal spray in her bare right hand while activating R12's nasal spray.</p> <p>On 1/9/25 at approximately 9:12 a.m., RN G was observed to pick up a box of tissues R12 had dropped onto the floor, with bare hands, and placed the now dirty box of tissues on top of R12's over bed table. No hand hygiene was performed prior to exit from the room.</p> <p>On 1/9/25 at 9:16 a.m., RN G was asked if they had used gloves during the administration of R12's nasal sprays. RN G stated, No, I did not use gloves at all. When asked about the application of barrier cream to R12's open, scratch wound, RN G acknowledged they had put the cream on the R12's open skin without donning gloves. RN G also confirmed they had not donned gloves prior to application of R12's transdermal patch, nor had they performed hand hygiene following application of R12's transdermal patch. RN G stated, I cannot do patches with gloves. RN G confirmed she had picked up R12's tissue box and placed it on top of R12's over bed table. When asked if the tissue box would be considered clean or dirty, RN G agreed the box from the floor would be dirty when placed on the over bed table. RN G did not perform hand hygiene following picking up the tissue box from the floor. RN G gathered the two nasal spray bottles in her dirty, bare hands as they exited the room. The nasal spray bottles were placed on top of the medication cart, without a barrier, and then placed back into the manufacturer's boxes in the medication cart.</p> <p>During an interview on 1/9/25 at 10:05 a.m., the NHA was informed of observation of ungloved hands during contact with skin and/or body fluids, failure to perform hand hygiene, and potential contamination of environmental surfaces. The NHA stated, What was [RN G] thinking. That is Nursing 101 (to perform hand hygiene). The NHA expressed understanding of the concern with infection control practices, especially during an outbreak of Norovirus within the facility and said RN G would be educated immediately.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the [Facility] Hand Hygiene policy, dated 4/2/2021 and reviewed 1/9/25 at 10:35 a.m., revealed the following, in part: Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility . Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub . 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice . The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves .</p> <p>Review of the Hand Hygiene Table, reviewed 1/9/25, revealed hand hygiene should be performed in the following situations, in part: .After caring for a person with known or suspected infectious diarrhea (such as Norovirus), when coming on duty, between resident contacts, after handling contaminated objects .before applying and after removing personal protective equipment (PPE), including gloves, before preparing or handling medications, before and after handling clean or soiled dressings, linens, etc., before performing resident care procedures . After handling items potentially contaminated with blood, body fluids, secretions, or excretions, when, during resident care, moving from a contaminated body site to a clean body site, after assistance with personal body functions, after sneezing, coughing, and/or blowing or wiping nose . When in doubt .</p>		