STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235558	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menominee Health Services	501 Second St, Box 246 Menominee, MI 49858

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 40383 Based on interview and record review, the facility failed to notify the Resident/Representative in writing with the reason for a transfer out of the facility for three Residents (#3, #13 and #17) of three residents reviewed for transfers out of the facility. Findings include: (All times are recorded in Eastern Daylight Time) Resident #3 (R3) A review of R3's medical record revealed a transfer to the hospital on 3/30/24. There was not a written notification of transfer sent to R3's representative. Resident #13 (R13) A review of R13's medical record revealed a transfer to the hospital on 1/3/24. Nursing progress note read in part: 1/3/2024 22:11 (2:11 PM) Nursing Note Narrative: Resident sent to (hospital name) at 2200. There was not a written notification of transfer sent to R13's representative. Resident #17 (R17) A review of R17's medical record revealed a transfer to the hospital on 9/13/23. There was not a written notification of transfer sent to R3's representative. During an interview on 4/3/24 at 8:40 AM, Social Services Director M explained she kept a log but did not do a written notification to the resident or responsible party. During an interview on 4/03/24 at 2:41 PM, the Director of Nursing (DON) stated, We only call the POA (Power of Attorney). I'm not positive but social services might do that. Nursing does not send a (written) notification. During an interview on 4/03/24 at 2:43 PM, the Nursing Home Administrator was not aware of a written notification and stated .maybe the social worker does it. During a follow up interview on 4/03/24 at 3:18 PM, the DON stated the facility did have the form but .We have not been sending it out.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235558	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on observation, interview, and record review, the facility failed to ensure two controlled medications were labeled when opened and securely stored in two medication carts out of two medication carts reviewed during the medication storage and medication administration tasks. Findings include: All times noted are Eastern Daylight Savings Time (EDST) unless otherwise noted. Observation of the ,d+[DATE] medication cart manned by Licensed Practical Nurse (LPN) B on [DATE] at 8:32 a.m., found an opened bottle morphine sulfate 100 mg (milligrams)/(per) 5 mL (milliliters) prescribed to R2 in the locked narcotic storage drawer. No 'open date' was noted on the open bottle of morphine. During an interview at this same time, LPN B confirmed the facility policy and practice was to date opened bottles and vials of medication when they were first opened. Review of R2's Resident Controlled Substance Record with LPN B, revealed the morphine sulfate was received by the facility on [DATE] at 0445 (4:45 a.m.) (Central Standard Time) (CST). Two doses had been administered: one on [DATE] at 0840 (8:40 a.m.) by LPN E, and a second dose on [DATE] by RN H. On [DATE] at 4:39 p.m., the 300-hall medication cart, manned by LPN O, was observed during medication pass to Resident R19. Seven medications had been prepared in a 30 cc (cubic centimeter) plastic medication cup, when R19's blister pack of Tramadol HCL 50 mg tablets was pulled from the locked narcotics drawer. A small white tablet was popped from the number four pill pocket on the blister pack but did not fall into the medication cup. LPN O and this Surveyor counted the medications in the cup, which should have totaled eight pills, and found only seven. This Surveyor had visualized the white pilled suspended from the aluminum backing of the blister pack as LPN O placed the blister pack back into the narcotics drawer. LPN O looked through the narcotics drawer three times, and this Surveyor also looked through the drawer, but the white tablet could not be found, and was not in the medication cup of the blister pack. LPN O stated, I hope it didn't go on the floor. This Surveyor found the pill on the floor, pointed it out to LPN O who immediately picked up the pill and placed it in the sharp's container. During an interview at this same time, LPN O was asked for the process of narcotic disposal, to which she replied she did need two nurses to dispose of narcotics, and they were disposed of in a drug buster, not in the sharp's container. Examination of R19's Tramadol blister pack with LPN O, found paper tape covering a previously opened number four pill slot on the back of the blister pack. When asked if it was acceptable to tape a previously opened narcotic package closed, LPN O confirmed it was not, and said the pill should have been wasted when it was found to be unsecured in the blister pack. During an interview on [DATE] at 4:30 p.m., the Director of Nursing (DON) confirmed that it was not acceptable for facility nursing staff to tape a previously opened narcotic closed and store it in the narcotic drawer for future use. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Menominee Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Second St, Box 246 Menominee, MI 49858	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration General Guidelines, dated ,d+[DATE], revealed the following, in part: . 8. Check expiration date on package/container. No expired medication will be administered to a resident. a. Drugs dispensed in the manufacturer's original container will be labeled with the manufacturer's expiration date. b. The nurse shall place a 'date opened' sticker on the medication if one is not provided by the dispensing pharmacy and enter the date opened . Once removed from the package/container, unused medication doses shall be disposed of according to the nursing care center policy .

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 13791 Based on interview and record review the facility failed to employ a full time dietitian, certified dietary manager or a certified food service manager to manage the food service department. Findings include: (All reported times are in EDT) On 4/2/24 at approximately 8:15 AM, an interview was conducted with Kitchen Manager (KM) A about her certification as a dietary manager. KM A stated she had not completed the Certified Dietary Manager's (CDM) course work, nor had begun or signed up for the course. Additionally, KM A stated she had no other food service training likened to a Certified Food Manager, Serve Safe certification or other. KM A stated the Registered Dietitian (RD) did not provide consultation on food service sanitation or other kitchen issues, rather, focused efforts on clinical needs. On 4/3/24 at approximately 1:30 PM, an interview with the Nursing Home Administrator (NHA) confirmed that the RD provided clinical support to the facility. A document provided by the NHA documenting the RD hours for the facility demonstrated the RD was on-site in the building a total of 13 hours for the three months January, February, and March 2024.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 13791 Based on observation, interview and record review the facility failed to employ sufficient staff with the appropriate competencies and skill to carry out the functions of the food and nutrition services. Findings include: (All reported times in EDT) On 4/2/24 at approximately 8:15 AM, an interview was conducted with Kitchen Manager (KM) A about her certification as a dietary manager. KM A stated she had not completed the Certified Dietary Manager's (CDM) course work, nor had begun or signed up for the course. Additionally, KM A stated she had no other food service training likened to a Certified Food Manager, Serve Safe certification or other. On 4/2/24 between 8:00 AM and 10:30 AM continued interviews were conducted with KM A and learned she was not familiar with the testing of the sanitizing solutions used in the three compartment sink and spray bottles used on food preparation surfaces, was not familiar with the chemicals used as sanitizing agents in the kitchen, stated staff were not using cooling logs to track left over foods being cooled to be served at a later date. On 4/2/24 at approximately 11:15 AM, KM A was observed operating the mechanical dish machine. KM A was observed going from the soiled end to the clean end and handling clean dishes without washing her hands in between tasks. An interview was conducted at this time with KM A stating We just don't have the staff to get this done. A review of the facility's employee list revealed the kitchen had only 6 people to perform dietary services, which includes: food preparation, food service, dish washing, kitchen cleaning, food ordering, food storage, ordering and other tasks necessary to operate a kitchen.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13791 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Findings include: (All reported times are in EDT) On 4/2/24 at approximately 7:30 AM, during the initial observation period in the kitchen, a 2 gallon Lexan container was observed in the Traulsen refrigerator. A label on the top identified the contents as Spag sauce and had a date of 3/31 then UB (use by) or Freeze by 4/3. An interview with Kitchen Manager (KM) A was conducted at this time and learned the cook responsible for putting the product had not documented the cooling process. KM A stated she was working on making a form for staff to follow. On 4/3/24 at approximately 2:30 PM, the same container was observed in the same refrigerator. An interview was conducted with KM A at this time who stated that it would be discarded. At 3:30 PM, KM A reported the product had been discarded. On 4/2/24 at approximately 8:30 AM two buckets with wiping cloths were observed on a food preparation table in the kitchen. An interview with KM A revealed that one bucket contained a detergent and water mixture and the other a clear water. When asked about sanitizing solution, KM A pointed to and lifted a spray bottle and stated that staff sprayed the work surfaces with it and it was the sanitizer. When asked if the product was pre-mixed and ready-to-use (RTU), KM A stated yes. When further questioned, it was learned the contents of the bottle were filled with a mixing dispenser located at the three compartment sink, which was a quaternary ammonium product. KM A was requested to test the solution but was unable to locate any test strips. When the contents of the spray bottle were tested , using QAC test strips, (provided by the surveyor) the result was 0 (zero) parts per million (PPM). The dispenser was activated at the three compartment sink, a container filled and tested with a new QAC test strip. The result showed the absence of any level of sanitizer. A review of the bottle of Quat revealed that a concentration of between 200 and 400 ppm were to be present to provide a proper sanitizing solution. On 4/3/24 at approximately 7:30 AM an interview was conducted with KM A related to the sanitizer used in the spray bottle. KM A explained that she had filled the bottle at the housekeeper's sink dispenser down the hall. When asked what the chemical being used to sanitize, KM A did not know. When asked if she knew what the proper concentration of the chemical was for sanitizing, she did not know. When asked if there were test strips available to test the concentration of the chemical, she did not know. It was learned the chemical was a hydrogen peroxide, dispensed from a housekeeping closet from a mixing dispenser. No information was available related to the proper concentration of the peroxide for food service use. On 4/2/24 at approximately 10:15 AM, KM A was observed conducting dish washing operations in the kitchen at the mechanical dish machine. KM A was observed to go from handling the soiled dishes from returned resident trays to the clean end, removing dishes from the racks after exiting the machine, without washing her hands. When asked if she knew what she had done in the situation, KMA acknowledged she had not washed her hands between functions. KM A further stated that due to the limited staff in the kitchen appropriate procedures were missed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/2/24 at approximately 7:45 AM Cook B was observed to have dropped a plastic container on the floor, proceeded to pick it up, take it to the dish machine area, then return to preparing the meal, without washing her hands. On 4/2/24 at approximately 10:25 AM KM A was requested to demonstrate proper sanitizing by the mechanical dish machine. A [NAME] digital maximum registering thermometer (MRT) was placed on a rack and placed into the machine. At the end of the cycle the MRT was removed and reported the temperature of sanitization was 145.7 F. When asked what the appropriate action would be, KM A stated she was not sure. The MRT was run an additional two cycles with similar results. KM A was asked if there were other mechanisms to test the machine. KM A produced test strips rated at 180 F. One of the strips was placed in the machine and allowed to run the entire cycle. When the dish machine was opened, the strip could not be located. It was explained these strips were not appropriate for testing the sanitizing cycle, in that, they confirmed the temperature of the water and not the temperature of the food contact surface. KM A stated she was not aware of this condition or procedure. KM A could not produce any previous logs demonstrating proper sanitizing of the machine. At 10:45 AM this surveyor returned to the kitchen and produced adhesive Thermolabels which were placed on a plate and allowed to run the entire cycle. Proper sanitizing was demonstrated using an appropriate and reliable test procedure. KM A was not aware of what the appropriate corrective action was necessary once the MRT did not validate the machine was properly sanitizing the food contact surfaces. KM A did not make any effort to re-wash the dishes that had been washed prior to the machine being identified as having a final rinse/food contact surface temperature of 160 F. KM A was not able to produce any testing mechanism which reliably ensured the dish machine was properly sanitizing food contact surfaces. On 4/2/24 at approximately 2:30 PM, the Folgers coffee machine located in the kitchen was observed to have a direct connection to the potable water supply. An approved (A.S.S.E. 1022) backflow preventer was not observed between the connection to the supply and the machine. On the back of the machine was stamped the following instructions to the installer: This dispenser is to be installed with adequate back flow protection to comply with local, state and federal regulations. On 4/3/24 at approximately 8:30 AM, an interview was conducted with Maintenance Supervisor (MS) C. MS C produced a picture on his phone showing a device on the water supply line. MS C stated there is an arrow on it, that what it is meaning an approved back flow prevention device. The device did not meet the standards for an approved back flow prevention device. On all days of the survey, (4/2 to 4/3/24) two hand sinks observed in the main kitchen (near the dietary office) and one near the dish washing room were noted to be constantly running. The faucets were unable to be shut off. An interview with Cook B revealed this condition had been ongoing for over two years. The FDA Food Code 2017 states: 2-102.11 Demonstration. Based on the RISKS inherent to the FOOD operation, during inspections and upon request the PERSON IN CHARGE shall demonstrate to the REGULATORY AUTHORITY knowledge of foodborne disease prevention, application of the HAZARD Analysis and CRITICAL CONTROL POINT principles, and the requirements of this Code. The PERSON IN CHARGE shall demonstrate this knowledge by: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(A) Complying with this Code by having no violations of PRIORITY ITEMS during the current inspection; Pf (B) Being a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM; Pf or (C) Responding correctly to the inspector's questions as they relate to the specific FOOD operation. The areas of knowledge include: (1) Describing the relationship between the prevention of foodborne disease and the personal hygiene of a FOOD EMPLOYEE; Pf (11) Explaining correct procedures for cleaning and SANITIZING UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT; Pf 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301. 12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLESP and: (E) After handling soiled EQUIPMENT or UTENSILS; P (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; P (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; P (H) Before donning gloves to initiate a task that involves working with FOOD; P and (I) After engaging in other activities that contaminate the hands.P 4-302.13 Temperature Measuring Devices, Manual and Mechanical Warewashing. (A) In manual WAREWASHING operations, a TEMPERATURE MEASURING DEVICE shall be provided and readily accessible for frequently measuring the washing and SANITIZING temperatures. Pf (B) In hot water mechanical WAREWASHING operations, an irreversible registering temperature indicator shall be provided and readily accessible for measuring the UTENSIL surface temperature.P 4-302.14 Sanitizing Solutions, Testing Devices. A test kit or other device that accurately measures the concentration in MG/L of SANITIZING solutions shall be provided. 4-501.11 Good Repair and Proper Adjustment. (continued on next page)

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	235558	A. Building B. Wing	04/03/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. 5-202.14 Backflow Prevention Device, Design Standard. A backflow or backsiphonage prevention device installed on a water supply system shall meet American Society of Sanitary Engineering (A.S.S.E.) standards for construction, installation, maintenance, inspection, and testing for that specific application and type of device. P 6-501.11 Repairing. PHYSICAL FACILITIES shall be maintained in good repair.

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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** 40383 Based on observation, Interview, and record review, the facility failed to perform process and outcome surveillance for all 34 facility residents. This deficient practice possibly contributed to an outbreak of Covid-19 resulting in the infection of 15 residents. Findings include: (All times are recorded in Eastern Daylight Time) On 4/2/24 at 7:18 AM, the facility door was observed to have a sign indicating there was a current Covid-19 outbreak in the facility. The Director of Nursing (DON) stated the Covid-19 outbreak included 15 residents and had begun with one Covid-19 positive resident on 3/28/24. On 4/3/24 at approximately 9:00 AM, the DON (who was also functioning as the facility Infection Preventionist [IP]) was interviewed on the infection control practices of the building. The DON/IP was asked about the tracking and trending of infections. The Covid-19 outbreak had started in March and the DON/IP was asked about her March tracking. She replied, I did not do my March infection control yet. We have QAPI (the Quality Assurance Performance Improvement meeting) on the third Tuesday of the month. I pull everything together from the previous month on the second or third week (to prepare for that meeting.) The facility did not have ongoing analysis of surveillance data and documentation of follow up activity in response to infections. The facility did not have real time tracking or a system of surveillance designed to identify possible communicable diseases or infections before they could spread to other persons in the facility. The policy titled: Infection Prevention and Control Program dated as reviewed/revised on 3/14/2023, read in part: . A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards. On 4/2/24 at 9:20 AM, Administrative Staff D was observed to remove a breakfast meal tray from the food cart and carry it into R22's room. This room had signage on the doorway indicating Personal Protective Equipment (PPE) should be worn into the room as R22 was Covid-19 positive. Staff D did not put on a protective gown, nor face shield, nor gloves. When Staff D exited the room the door signage was pointed out and Staff D was asked if she should have worn PPE into the Covid-19 positive room. Staff D replied, Oh yes, I did not even realize he is positive. I have been gone from work. The policy titled: Infection Prevention and Control Program dated as reviewed/revised on 3/14/2023, read in part: Standard Precautions: a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services.c. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The policy titled: Personal Protective Equipment dated as reviewed/revised on 3/17/2023, read in part: This facility promotes appropriate use of personal protective equipment to prevent the transmission of pathogens to residents, visitors, and other staff. Definitions: Personal protective equipment, or PPE, refers to a variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with pathogens. It includes gloves, gowns, face protection (facemasks, goggles, or face shields), and respiratory protection (respirators). Policy Explanation and Compliance Guidelines: 1. All staff who have contact with residents and/or their environments must wear personal protective equipment as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely. 2. PPE will be utilized as part of standard precautions regardless of a resident's suspected or confirmed infection status. 35103 During an observation on 4/2/24 at 7:42 a.m., CNA K exited room [ROOM NUMBER] wearing only an N95 face mask. CNA K removed the N95 mask with bare hands, set the dirty N95 mask on top of the PPE cart outside of room [ROOM NUMBER]. CNA D used her contaminated hands to go through the clean masks on the PPE cart to get a new surgical mask and placed it on her head. CNA K picked up the dirty N95 face mask by touching the front of the mask with her bare hands, picked up plastic bags, and a piece of garbage from the floor. CNA K walked down the entire length of the hall with the dirty PPE (in a plastic bag) and garbage in her bare hands to dispose of the garbage near the kitchen. CNA K returned back down the 300-hall and was not observed to complete hand hygiene anywhere during the above observation. During an interview at this same time, CNA K confirmed she had removed her dirty N95 face mask with bare hands and contaminated her hands. She had not performed hand hygiene since touching the dirty mask and the garbage. CNA K said she should have performed hand hygiene after picking up the garbage from the floor but acknowledged she had not done that. During an observation on 4/2/24 at 9:30 a.m., Maintenance Director (Staff) C exited a COVID positive room on the 300-hall wearing a face shield and face mask. Staff C was observed placing the face shield back on his head as he exited the room. Staff C did not disinfect the face shield following room exit. During an interview at this same time, when asked what he would do to the faceshield when he exited the room of a COVID-19 positive resident after delivering a meal tray into the room, Staff C stated, I probably need to sanitize it. I will get some wipes. During an observation on 4/02/24 at 12:50 p.m., CNA N exited a Covid positive resident room, removed all PPE, but did not perform hand hygiene. CNA N reached into the clean PPE supplies with contaminated hands. CNA N donned a new surgical mask and reached into the Covid-19 positive room and removed the partially eaten meal try from the room. The meal tray was removed with bare hands, and the tray rested on the front of her scrub uniform as she walked the meal tray down the hall to the kitchen. Signage posted on the PPE bin How to Safely Remove Personal Protective Equipment read: Wash hands or use an alcohol-based hand sanitizer immediately after removing all PPE. An observation of medication administration and tube feeding for R6 on 4/3/24 at 10:19 a.m., was completed with Registered Nurse (RN) G. RN G wore a gown, surgical mask, and face shield into R6's Enhanced Barrier Protection (EBP) room. No gloves were donned, and all medication and tube feeding administrations, including wiping of the feeding tube itself were performed with bare hands by RN G. RN G spilled water on R6's overbed table, and the overbed table was wiped with a permeable paper cloth and bare hands. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235558	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Menominee Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Second St, Box 246 Menominee, MI 49858	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 10:45 a.m. on 4/3/24 RN G was observed with long, polished fingernails, as she used her bare hands to remove her isolation gown and face shield at the medication cart in the hallway, outside of R6's room. The isolation gown was placed in the medication cart small garbage can, sticking out of the top of the can. During an interview during this time RN G was asked what PPE was to be donned for tube feeding administrations with EBP. RN G stated, Gowns and Masks. Review of the Enhanced Barrier Precautions policy, dated 3/25/24, revealed the following, in part: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities . 3. Implementation of enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray . d. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. 4. High-contact resident care activities include . g. Device care or use: central lines, urinary catheters, feeding tubes . Review of Contact/Droplet Precautions Signage on the PPE cart outside of room [ROOM NUMBER] read: Any resident on Contact/Droplet Precautions: 1. Keep privacy curtains pulled between residents. 2. Keep door shut and check on residents frequently. 3. Prior to entering room: a. Complete hand hygiene b. Put on gown. c. Put on N95 if fit, otherwise use a surgical mask. d. Put on face shield. e. Put on gloves. 4. Prior to leaving room: a. Remove gloves, b. Remove gown and discard in trash (DO NOT REUSE). c. Exit room and perform hand hygiene. d. Remove face shield (wipe off with bleach wipe, contact time 1 minute). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	e. Remove mask and discard in trash. f. Perform hand hygiene. g. Apply new mask. Remember: you must wear full PPE every time you enter a room with Transmission-based Precautions. If able, leave dedicated equipment in the resident's room (i.e. glucometer, stethoscope, etc.) All share equipment must be disinfected before using on another resident (i.e. lifts, thermometer, etc.) Any new or worsening symptoms noted for a resident: place on precautions, obtain a rapid COVID test, if negative, complete a PCR test.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 40383 Based on observation, interview, and record review, the facility failed to provide sufficient time for the Infection Preventionist (IP) to implement the Infection Control program for all 34 residents residing in the building. This deficient practice impacted the ability of the IP to perform the duties of infection surveillance activities. Findings include: (All times are recorded in Eastern Daylight Time.) On 4/2/24 at 7:18 AM, the facility door was observed to have a sign indicating there was a current Covid-19 outbreak in the facility. The Director of Nursing (DON) stated the Covid-19 outbreak involving 15 residents had begun on 3/28/24. The surveyors were advised the DON was also the Infection Preventionist (IP) but that day she would be working the floor or be taking on a floor nurse assignment passing medications and performing duties specifically for the residents on one assignment due to staffing issues. On 4/2/24 at approximately 11:00 AM, the DON/IP was asked when she could be interviewed to discuss the infection control practices in the facility. The DON/IP requested the discussion of the facility infection prevention and the current outbreak of Covid-19 take place on the following day as she was filling in for a floor nursing position and was short on time. On 4/3/24 at approximately 9:00 AM, the DON/IP was interviewed on the infection control practices of the building. The DON/IP was asked about the tracking and trending of infections. It was determined that the facility did not have ongoing analysis of surveillance data and documentation of follow up activity in response to infections. The facility did not have real time tracking or a system of surveillance designed to identify possible communicable diseases or infections before they could spread to other persons in the facility. Several infection control issues on Personal Protective Equipment and hand hygiene were discussed with the DON/IP who stated education had occurred, but maybe more was needed. During a further interview on 4/3/24 at 4:48 PM, the time necessary for the IP to properly assess, develop, implement, monitor, and manage the infection control program for the facility was discussed with the DON/IP. She stated, I have been working the floor due to staffing issues. The staffing schedule was reviewed with the DON/IP and it was noted that 12 of the last 23 days in March and 12 of the first 21days of April the DON/IP was scheduled as a floor nurse. (Five of the April shifts were scheduled for 12-hour shifts of 6 AM to 6 PM.) The DON/IP said this made it hard to do all the tasks for both positions of DON and IP. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The policy titled: Infection Prevention and Control Program dated as reviewed/revised on 3/14/2023, read in part: Policy Explanation and Compliance Guidelines: 1. The designated Infection Preventionist is responsible for oversight of the program and serves as a leader 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 . The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's QAA/QAPI (Quality Assurance Programs) . The Infection Preventionist, with oversight from the Director of Nursing, serves as the leader of the antibiotic stewardship program . Information on various infectious diseases is available from our Infection Preventionist . The Infection Preventionist shall coordinate screening procedures in case of widespread exposure of staff to any infectious disease .