STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525556	A. BUILDING _____ B. WING _____	**04/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKSIDE CARE CENTER	**3506 WASHINGTON RD KENOSHA, WI 53144**

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** - Some	**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 properly prevent the spread of infections such as COVID-19 as evidenced by failures to: (1) follow infection control practices related to the transport and storage of clean linens in four halls; (2) perform hand hygiene when providing assistance to one (R1) resident; and, (3) perform hand hygiene when delivering meal trays for four (R2, R3, R4 and R5) residents in the sample of five. The failures by staff to perform hand hygiene while delivering meal trays and providing assistance to residents and to properly transport and store clean linens to prevent contamination had the potential to affect residents residing on four units (Rehab, 200, 400 and 700 halls) of the facility. Findings include: 1.A. Observation of a laundry staff (E1) on 4/22/20 at 11:23am revealed that E1 was transporting clean linens to the Rehab Hall. E1 was transporting the clean linens using a cart that was not covered. In an interview with E1 when asked if the clean linens should have been covered during transport to the Rehab Unit, E1 stated, It's not usually covered (during transport). When asked why it was important to cover the clean linens during transport, E1 stated, For sanitation, to prevent contamination. The Administrator, who was in the area during this observation and interview, added, (The clean linens were) supposed to be covered. B. Observation of the linen cart in the shower room on 400 Hall, on 4/22/20 at 12:16pm, revealed that the linen cart was not covered. The shower room door was also wide open. C. Observation of the linen cart in the shower room on 200 Hall, on 4/22/20 at 12:40pm, revealed that the linen cart was not covered. The shower room door was also wide open. D. Observation of the linen cart in the shower room on 700 Hall, on 4/22/20 at 3:09pm, revealed that the linen cart was not covered. The shower room door was also wide open. Review of the resident room roster provided by the facility on 4/22/20 at approximately 11am, revealed 26 residents resided on the Rehab Unit, 14 residents on the 200 Hall, 19 residents on the 400 Hall and 18 residents on the 700 Hall. In an interview with the DON on 4/22/20 at 1:34pm when told about the observations of linen carts not being covered, the DON stated, (Linen carts) should be covered. Review of the facility's undated Linen & Laundry Policy revealed under Policy: 1. All linen carts must be covered when transporting or storing clean laundry . 2. Review of the current [DIAGNOSES REDACTED]. Observation of Nursing Assistant (NA)1 on 4/22/20 at 11:53am revealed that NA1 assisted R1 with transferring an iced water from a plastic cup to R1's tumbler. Without performing hand hygiene, NA1 went into R1's room and immediately removed the lid on R1's tumbler to transfer the iced water from the plastic cup to the tumbler per R1's request. In an interview with NA1 when asked if she should have performed hand hygiene before assisting R1 with her water, NA1 stated, (I) should have done it. In an interview with the Director of Nursing (DON) on 4/22/20 at 1:34pm when told about the observation of NA1 not performing hand hygiene before assisting R1 with transferring her water from the plastic cup to her tumbler, the DON stated, She should have washed her hands. 3. Observation on 4/22/20 at 12:10pm revealed that NA2 brought lunch trays to R2's, R3's, R4's and R5's rooms. NA2 was not observed performing hand hygiene before delivering the lunch trays to the four rooms. NA2 assisted in setting up the lunch trays on residents' over-bed tables then NA2 left their rooms without doing hand hygiene. In an interview with NA2 on 4/22/20 at 12:26pm when asked if she should have performed hand hygiene when delivering meal trays to the residents' rooms, NA2 stated, (I) should do it in between rooms. Review of the current [DIAGNOSES REDACTED]. In addition, some diabetes-related health issues, such as nerve damage and reduced blood flow to the extremities, increase the body's vulnerability to infection.). Further review of R4's current [DIAGNOSES REDACTED]. In an interview with DON on 4/22/20 at 1:34pm, when told about the observations of lapses in hand hygiene by the NA2 while delivering meal trays to residents, the DON stated, (There should be) hand hygiene in between rooms. In an interview with the Administrator on 4/22/20 at 4:37pm, the Administrator stated, (There was) no policy that addresses doing hand hygiene in between resident rooms (when delivering meal trays). Review of the facility's undated Brookside's Hand Washing Policy revealed Hand washing doesn't take much time and effort, but it is the single most important step in preventing illness/communicable disease and significantly reducing the spread of infection . Further review of the same policy revealed under Purpose: The main reason if to cleanse the hands of pathogens, including bacteria or viruses and chemicals that can cause personal harm or disease. Review of the same policy further indicated, .Some situations that require hand hygiene including but not limited to: .Before and after assisting a resident with meals . The same policy stated, Clean hands are the single important factor in preventing the spread of dangerous germs and antibiotic resistance in health care settings .Compliance with hand hygiene in the USA could save 20,000 lives per year!!!

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