STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525542	A. BUILDING _____ B. WING _____	05/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAK RIDGE CARE CENTER	1400 8TH AVE UNION GROVE, WI 53182

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 properly prevent the spread of infections such as COVID-19 as evidenced by failures to: (1) ensure that pulse oximeter (medical device used to measure pulse rate and oxygen saturation level), blood pressure (BP) cuff, stethoscope (medical device used for auscultation, or listening to sounds produced by the body) and thermometer (medical device used to measure body temperature) shared among residents were properly cleaned and disinfected before and after resident use for two (R1 and R12) residents; (2) follow infection control practices related to the use of glucometer (medical device used to measure sugar levels in the blood) for four (R2, R3, R8 and R9) residents; (3) perform hand hygiene when delivering clean laundry for four (R4, R5, R6 and R7) residents; (4) follow infection control practices related to the transport of clean laundry in one unit (Rehabilitation Unit); and, (5) clean and disinfect a mechanical lift in between resident use for two (R10 and R11) residents. Staff failures to disinfect shared medical equipment, handle medical equipment to prevent contamination, perform hand hygiene while delivering clean laundry, follow infection control practices related to the transport of clean laundry and disinfect a mechanical lift in between resident use had the potential to affect all residents who resided in the facility at the time of the survey. Findings include: 1.A. Observation of Registered Nurse (RN)1, on 5/7/20 at 10:48am, revealed RN1 used the pulse oximeter, BP cuff, stethoscope and thermometer to check R1's vital signs (oxygen saturation level, pulse rate, BP, lung sounds and temperature) in R1's room. After using the pulse oximeter, BP cuff, stethoscope and thermometer, RN1 kept the medical devices in the treatment cart. In an interview with RN1 on 5/7/20 at 12:21pm, when asked if she should have cleaned and disinfected the medical devices after use with R1, RN1 stated, I should have but did not before keeping them in the treatment cart. In an interview with the Director of Nursing (DON) on 5/7/20 at 2:22pm, when told about the observation of RN1 not sanitizing the medical devices after resident use, the DON stated, (Staff should use) bleach based wipes. Wipe it (medical device) off with any wipes to clean then (use) bleach wipes (to disinfect). B. Observation of RN2, on 5/7/20 at 1:45pm, revealed RN2 used the pulse oximeter, BP cuff, stethoscope and thermometer to check R12's vital signs (oxygen saturation level, pulse rate, BP, lung sounds and temperature) and to do physical assessment in R12's room. Before using the medical devices with R12, RN2 used the PDI Sani-Hands (a hand hygiene solution for staff, visitors, patients or residents who cannot get out of bed to clean their hands) to clean the medical devices. In an interview with RN2 on 5/7/20 at 2:08pm, RN2 verified that she used PDI Sani-Hands to clean the medical devices before use with R12. RN2 also stated, I should have used the bleach wipes (to disinfect the medical devices). In an interview with the DON and the Administrator on 5/7/20 at 2:53pm, when told about the observation of RN2 using the PDI Sani-Hands to clean the medical devices before resident use, the Administrator stated, (We) will have to check the specific product. Review of the facility's Cleaning and Disinfecting of Medical Equipment, Maintenance Tools, and Housekeeping Items policy and procedure updated May 2019 revealed under Policy: All medical devices, maintenance tools, and housekeeping items will be cleaned to prevent the spread of infection. Further review of the same policy and procedure revealed under Procedure: 1. All items once brought into a resident's room are considered dirty and must be disinfected before they are brought out of the resident's room .4. If the object to be disinfected does not come with manufactures (sic) guidelines for disinfection, staff will: a. Obtain a facility approved wipe disinfectant .5. If a wipe is not available for use, obtain a sprayable disinfectant and a cloth or paper towel . According to the Infection Preventionist's Guide to Long-Term Care published by the Association for Professionals in Infection Control and Epidemiology, Inc. (APIC) in 2013 revealed on page 166 under Maintaining Equipment, All equipment approved for use in the LTCF (Long Term Care Facility) must be cleaned and disinfected according to manufacturer instructions and included in the facility's policies and procedures .All equipment policies should contain the following essential infection prevention elements: Immediately clean/disinfect all equipment with the facility-approved EPA (Environmental Protection Agency) hospital grade disinfectant when visibly soiled or after use with residents .Always follow manufacturer's cleaning and disinfection recommendations . Review of Ten Tips for Cleaning and Disinfecting Shared Medical Equipment sent by Medline on January 29, 2010 to Medline customers revealed, .7. If no visible organic material is present, disinfect the exterior surfaces after each use using a cloth or wipe with either an EPA-registered detergent/germicide with a turberculocidal or HBV/HIV label claim, or a dilute bleach solution of 1:10 to 1:100 concentration . 2. Review of R2's, R3's, R8's and R9's 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.). A. Observation of Student Nurse (SN)1 on 5/7/20 at 11:17am, revealed SN1 used the FORA GD20 glucometer to check R2's blood sugar in his room. Without using any barrier to protect the glucometer case and the glucometer from contamination by the surface of the over-bed table, SN1 sat the glucometer on R2's over-bed table. SN1 went back to the medication cart and sat the contaminated glucometer case and glucometer on top of the medication cart without using any barrier. SN1 wiped the glucometer with a PDI Sani-Cloth Bleach wipe for 10 seconds, put it back in the glucometer case and kept it in the medication cart. Observation of SN1 also revealed SN1 administered insulin to R2 via insulin pen after checking R2's blood sugar. Without using any barrier to protect the insulin pen from contamination by the surface of the medication cart and R2's over-bed table, SN1 sat the insulin pen on top of the medication cart and R2's over-bed table. After administering R2's insulin, SN1 kept the contaminated insulin pen in a resealable bag then placed it in the medication cart without cleaning and disinfecting it. B. Observation of Licensed Practical Nurse (LPN)1, on 5/7/20 at 11:28am, revealed LPN1 used the FORA GD20 glucometer to check R3's blood sugar in R3's room. Without using any barrier to protect the glucometer case and the glucometer from contamination by the surface of R3's over-bed table, LPN1 sat the glucometer case and glucometer on top of the over-bed table. After checking R3's blood sugar, LPN1 administered insulin to R3 via insulin pen. Without using any barrier to protect the insulin pen from contamination by the surface of the medication cart and R3's over-bed table, LPN1 sat the insulin pen on top of the medication cart and R3's over-bed table. After administering R3's insulin, LPN1 kept the contaminated insulin pen in a resealable bag then placed it in the medication cart without cleaning and disinfecting it. C.1) Observation of Medication Technician (MT)1, on 5/7/20 at 11:49am, revealed MT1 used the FORA GD20 glucometer to check R8's blood sugar in R8's room. Without using any barrier to protect the glucometer case from contamination by the surface of the medication cart, MT1 sat the glucometer case on top of the medication cart. MT1 went to R8's room and sat the contaminated glucometer case and glucometer on R8's over-bed table. Before leaving R8's room, MT1 sat the contaminated glucometer case on top of R8's dresser while she was washing her hands in R8's washroom. MT1 washed her hands for only eight seconds. After checking R8's blood sugar, MT1 went back to the medication cart and sat the contaminated glucometer case on top of the medication cart without using any barrier. MT1 wiped the glucometer with the PDI Sani-Cloth Bleach wipe for six seconds and stated, We wipe it (glucometer) after (use) and let it dry. MT1 held the glucometer with her bare hands to check R8's blood sugar result then placed the glucometer back on top of the contaminated glucometer case. 2) Observation of MT1 on 5/7/20 at 11:57am, revealed MT1 used the FORA GD20 glucometer to check R9's blood sugar in R9's room. Without using any barrier to protect the glucometer case and glucometer from

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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When asked about the contact time (also known as the wet time and the time that the disinfectant needs to stay wet on a surface in order to ensure efficacy) of the PDI Sani-Cloth Bleach wipe, the DON stated, We are not aware off the top of our head. We have to read. According to the PDI Sani-Cloth Bleach Germicidal Disposable Wipe General Guidelines For Use, .4. Treated surface must remain visibly wet for a full four (4) minutes. Use additional wipe(s) if needed to assure continuous 4 minute wet contact time . According to the FORA GD20 Operations & Procedure Manual, under Cleaning and Disinfection Procedures, .Use a lint free cloth dampened with soapy water or [MEDICATION NAME] (70% - 80%) to clean the outside of the blood glucose meter .To disinfect the meter, dilute 1 ml (milliliter) of household bleach (5% - 6% sodium hypochlorite solution) in 9 ml of water to achieve a 1:10 dilution (final concentration of 0.5% - 0.6% sodium hypochlorite). The solution can then be used to dampen a paper towel .Then use the damped towel to thoroughly wipe down the meter. Please note that there are commercially available 1:10 quaternary/alcohol wipes and bleach wipes from a variety of manufactures (sic) .Please follow the disinfectant product label instructions to ensure proper drying time . Review of the facility's Completing an Accucheck (Blood Glucose Monitoring) policy and procedure dated 2015 revealed, .3. Place necessary supplies on a clean surface, new clean tissue, new paper towel, or other clean barrier .22. Clean glucometer per the Cleaning and Disinfecting of Glucometer Policy. Review of the facility's undated Cleaning and Disinfection of Glucometers policy and procedure revealed under Policy: .All equipment, glucose meters, lancets, syringes and germicidal wipes will be provided and maintained in a sanitary and operable condition . Further review of the same policy and procedure revealed under Procedure: .Open, unfold and use first germicidal wipe to remove blood or body fluid. Dispose of (sic) used wipe and use second germicidal wipe to thoroughly wet the surface of the meter .Follow product manufacturer's instructions for contact time. Let air dry. Replace into carry (sic) case . According to a Centers for Disease Control and Prevention (CDC) article titled, Guidelines for Environmental Infection Control in Health-Care Facilities published on 6/6/03, revealed under Recommendations - Environmental Services on subsection Cleaning and Disinfecting Strategies for Environmental Surfaces in Patient Care Areas, .3. Use barrier protective coverings as appropriate for noncritical surfaces that are 1) touched frequently with gloved hands during the delivery of patient care; 2) likely to become contaminated with blood or body substances . 3. Observation of a laundry staff (E1) on 5/7/20 at 11:38am revealed that E1 was delivering clean laundry to R4's, R5's, R6's and R7's rooms. Further observation revealed that E1 entered the four rooms to put clean laundry in the residents' dressers. E1 went in and out of the four rooms without performing hand hygiene. In an interview with E1 on 5/7/20 at 11:43am when asked if she should have performed hand hygiene in between resident rooms while delivering clean laundry, E1 stated, I sanitized (my hands) before coming inside the unit and before going out but not in between rooms. I didn't know that (that she should perform hand hygiene in between resident rooms). Review of R4's current [DIAGNOSES REDACTED]. Further review of R6's current [DIAGNOSES REDACTED]. In an interview with the DON and the Administrator on 5/7/20 at 2:41pm, when asked of their expectations of laundry staff when delivering clean laundry to residents' rooms, the DON stated, (Laundry staff should perform) hand hygiene in between (resident) rooms (when delivering laundry). Review of the facility's undated Linen and Laundry Distribution and Transportation policy and procedure revealed under Policy: It is the policy of Oak Ridge Care Center to handle and transport linens and laundry with appropriate measures to prevent the spread of infection. Clean linens must be distributed by methods that ensure cleanliness . Further review of the same policy and procedure revealed under Procedure: .Housekeeping personnel shall sanitize their hands before and after each resident room . 4. Observation of E2 on 5/7/20 at 1pm revealed that E2 was delivering clean laundry in the Rehab Unit using a cart that was not covered. In an interview with E2 on 5/7/20 at 1:04pm, when asked if the linen cart should have been covered, E2 stated, (It) should have been covered. E2 further stated that he was not aware that there was a cover until the surveyor showed him the linen cart cover. Review of the resident room roster provided by the facility on 5/7/20 at approximately 11:13am, revealed nine residents resided in the Rehab Unit. In an interview with the Administrator on 5/7/20 at 2:47pm, when told about the above observation, the Administrator stated, (The linen) cart should be covered. Review of the facility's undated Linen and Laundry Distribution and Transportation policy and procedure revealed under Policy: It is the policy of Oak Ridge Care Center to handle and transport linens and laundry with appropriate measures to prevent the spread of infection. Clean linens must be distributed by methods that ensure cleanliness and protect from dust and soil. Further review of the same policy and procedure revealed under Procedure: All linens and laundry shall be stored and distributed in covered linen carts . 5. Observation on 5/7/20 at 1:02pm revealed that NA1 and NA2 were coming out of R10's room with a mechanical lift, then NA1 and NA2 went to R11's room with the same mechanical lift. In an interview with NA1 and NA2 on 5/7/20 at 1:23pm, when asked if they should have cleaned and disinfected the mechanical lift after using it with R10 and before using it with R11, NA1 stated, (We) forgot to sanitize. (We) should have sanitized (it) before using (it with R11). Review of the current [DIAGNOSES REDACTED]. Further review of the current [DIAGNOSES REDACTED]. In an interview with the DON on 5/7/20 at 3:01pm, when told about the above observation of NA1 and NA2, the DON stated, (They) should sanitize (the mechanical lift in between resident use). Review of the facility's undated Mechanical Lift Disinfection and Inspection policy and procedure revealed under Procedure: Staff should disinfect all mechanical lift surfaces before and after use, especially between residents, to prevent cross contamination and promote proper infection control .