STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525443	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ONALASKA CARE CENTER	1600 MAIN ST ONALASKA, WI 54650

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 prevent the spread of infections and transmission of COVID-19 as evidenced by failure to adhere to infection control practices related to: proper disinfection of shared medical equipment and faceshield; isolation precautions; proper glove usage and storage of clean linens. These practices had the potential to affect all residents residing in the facility. Findings include: 1. A. On 6/24/20 at 11:20 am, Registered Nurse 1 (RN1) was observed checking the oxygen saturation level (O2 sat is amount of oxygen in a blood cell) and temperature of R1 in room [ROOM NUMBER]. Using an alcohol pad, RN1 wiped the pulse oximeter (device that clips on your finger, toe, or earlobe to measure blood oxygen saturation) for eight seconds. RN1 opened another alcohol pad and wiped the thermometer for nine seconds. At 11:22 am, RN1 entered R2's room to check R2's O2 sat level and temperature. After the procedure, RN1 wiped the pulse oximeter with one alcohol pad for eight seconds and took another alcohol pad and wiped the thermometer for seven seconds. At 11:25 am, RN1 went to R3's room to check R3's O2 sat level and temperature. RN1 wiped the pulse oximeter with alcohol pad for seven seconds and took another alcohol pad and wiped the thermometer for nine seconds. When asked if she always used alcohol pads to wipe the pulse oximeter and thermometer, RN1 stated, Yes. When asked if she uses the Hydrogen Peroxide disinfecting wipes on any equipment, RN1 stated I usually do that when I'm all done. Then at 11:26 am, RN1 proceeded to wipe the pulse oximeter for five seconds and seven seconds on the thermometer using the hydrogen peroxide wipe and dispose off the wipe. Review of facility's policy titled Equipment Cleaning dated 4/23/20 revealed, Purpose: Maintain infection prevention techniques to help prevent the spread of illness. Under Procedure, 1. Vital Machines, cuffs, thermometer - outside avoiding sensor part, stethoscopes, face shields, goggles, weight scales, commodes, toilets will be cleaned after each resident use with Hydrogen Peroxide wipes .2. Contact time for Hydrogen wipes is 1 minute, wipe surface and make sure surfaces are wet and remain wet for 1 minute .3. Special cleaning consideration on electronic equipment, oxygen sensors, infrared thermometer sensors .Sensor type equipment should have 20 second scrub with alcohol wipes then air dry for 5 to 10 seconds .5. Surfaces made wet with the cleaning solution, then remain wet for the contact time of 1 minute for hydrogen peroxide for normal cleaning .7. Make sure contact time completed and equipment dry before next use. B. Review of facility's list titled Residents admitted in the Care Center in the last 2 weeks (6/10/20 to 6/24/20) revealed, (R4) - room [ROOM NUMBER] - Adm (admission) 6/17. COVID testing 6/16, 6/10 at Gundersen - Both were negative. R4 was placed on droplet and contact precautions. On 6/24/20 at 12:00 pm, Nursing Assistant1 (NA1) was observed entering R4's room. At 12:02 pm, NA1 exited the room and removed the personal protective equipment (PPE) in the following sequence: gloves, gown and mask. NA1 kept her faceshield on. NA1 sanitized her hands and put on a new facemask. NA1 failed to disinfect her faceshield after exiting an observation room. On 6/24/20 at 12:04 pm, when Acting Administrator was asked about her expectation from staff on donning and doffing of PPE, the Acting Administrator stated, Staff should put on double gloves. Before coming out, they remove the outer gloves inside the room. Staff then remove their isolation gown and dispose it in the garbage bin marked outside of the room. Staff use peroxide wipe to sanitize their face shield then dispose of the inner gloves. On 6/24/20 at 12:07 pm, when asked what she missed, NA1 stated she should have disinfected her face shield after coming out of an observation room and added, I should have done that after leaving the room. During interview with the Assistant Director of Nursing (ADON) on 6/29/20 at 1:22 pm, when asked about her expectation from staff on disinfection of equipment, the ADON stated, So they (staff) are supposed to clean the equipment and per policy, clean it and wait for the contact time before they use it on different person. The ADON further stated, Wet the surfaces for a minute. They can set the equipment down and wait. Review of facility's procedure titled Doffing PPE dated 6/17/20 revealed under Faceshield/Goggles, Leave room, apply gloves, remove faceshield/goggles and wipe with disinfectant wipe, wiping inside first, then outside and let shield/goggles air dry. In a CDC article titled Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic dated June 19, 2020 revealed under Environmental Infection Control, All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies. Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly. Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for [DIAGNOSES REDACTED]-CoV-2 in healthcare settings .Refer to List N on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging [MEDICAL CONDITION] pathogens program for use against [DIAGNOSES REDACTED]-CoV-2. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html In a CDC article titled Strategies for Optimizing the Supply of Eye Protection dated June 28,2020 under Implement extended use of eye protection revealed, If a disposable face shield is reprocessed, it should be dedicated to one HCP and reprocessed whenever it is visibly soiled or removed (e.g. when leaving the isolation area) prior to putting it back on. https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html#conventional-capacity In a CDC article titled Personal Protective Equipment: Questions and Answers dated March 14, 2020 revealed under Gloves, Is double gloving necessary when caring for suspected or confirmed COVID-19 patients in healthcare settings? CDC Guidance does not recommend double gloves when providing care to suspected or confirmed 2019 COVID patients. https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirator-use-faq.html 2. A. On 6/24/20 at 11:30am, droplet and contact precaution signage was observed posted and an isolation set-up was placed outside of R5's room. Two garbage bins with lids were observed outside of R5's room: one garbage bin with lid was used for soiled reusable isolation gowns and the second garbage bin with lid was used for dirty linens. An open small garbage outside of R5's room was used for soiled gloves and used disinfecting wipes. Review of R5's nurses notes dated 6/24/20 at 10:25 pm revealed, COMMENTS: Was reported resident displayed symptoms of runny nose, myalgia, occasional lethargy, and elevation of temperature that did not reach or exceed 100.0. In response to aforementioned symptoms, resident was placed on droplet precaution and COVID tested . COVID test result was negative and no reported symptom observation noted on 6/24/20 as of 2221 (10:21pm). Will continue droplet precaution until resident exceeds 48 hours without symptom. RESPIRATORY INFECTION: placed on isolation, (IC DON) B. Review of R4's medical chart revealed an admission date of [DATE]. On 6/24/20 at 11:47 am, droplet and contact precaution signage was observed posted and an isolation set-up was placed outside of R4's room. Two garbage bins with lids and one small open garbage bin were placed outside of R4's room. One garbage bin with lid was used for soiled reusable gowns and the second garbage bin with lid was used for dirty linens. The open small garbage was used for soiled gloves and used disinfecting wipes. At 11:58 am, when asked, RN2 stated, I guess since the COVID. Not sure why it is outside. Usually it's inside the room. During interview with the Assistant Director of Nursing (ADON) on 6/29/20 at 1:22 pm, when asked about the placement of garbage bins for isolation rooms, the ADON stated, Usually most of them (supplies) are disposed in the room. The residents are agitated and we left it (garbage bins) outside of the room. The ADON further stated that it was a safety concern because one resident had mobility issues and the other resident got agitated. Review of Isolation room sign

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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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) provided by the facility revealed under Contact Precautions, Providers and staff must also .Discard gloves before room exit. Discard gown before room exit. Review of facility's policy titled Isolation Guides dated 6/16/20 revealed under Procedure for Contact Precautions, Gloves .4. Gloves will be removed and discarded before leaving the resident's room, hands will immediately washed with soap and water, or waterless hand sanitizer will be used .Gowns .4. The gown will be removed and appropriately discarded before leaving the resident's environment. In a CDC article titled Preparing for COVID-19 in Nursing Homes dated June 25, 2020 under Core Practices revealed, Provide Supplies necessary to Adhere to Recommended Infection Prevention and Control Practices .Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html In an article titled Annex E Isolation rooms or areas dated 2014 revealed under E.1. Preparation of the isolation room or area, Place appropriate waste bags in a bin. If possible, use a touch free bin. Ensure that used (i.e. dirty) bins remain inside the isolation rooms. https://www.ncbi.nlm.nih.gov/books/NBK 1/?report=printable 3. A. On 6/24/20 at 11:43 am, while in the 300 unit, a clean linen cart with folded linen and towels was observed inside the shower room, exposed. The clean linen cart was next to the hamper for dirty linen with the lid left open. This was confirmed by NA2. B. On 6/24/20 at 12:22 pm, in the 300 unit, the door to the clean linen closet was observed open. Gowns, pads and other supplies are folded on the shelves but exposed. NA3 confirmed the observation. C. On 6/24/20 at 1:57 pm, while in the 100 unit, a clean linen cart was observed inside the shower room. Folded towels and clean linen were on the second and third shelves, exposed. D. On 6/24/20 at 2:00 pm, four linen carts with folded blankets, gowns and pads were observed in the main linen room. The front cover for the four linen carts were pulled back exposing the clean linen. The door to the main linen room was left open. During interview with the ADON on 6/29/20 at 1:22 pm, when asked how staff should store and handle clean linen, the ADON stated that clean linen should be covered before they get delivered to residents' rooms. Review of facility's policy titled Linen Handling dated 4/24/20 revealed, Purpose: Maintain infection prevention techniques to help prevent the spread of illness. Under Procedure, it revealed, 6. Linen needed on units is to be placed on wing linen carts and then covering placed over when in transport or not in use .8. Linen may be placed in clean linen closets on unit and doors on wing linen closets closed when not in use. In a CDC article titled Appendix D - Linen and Laundry Management dated March 27, 2020 under Best practices for management of clean linen revealed, Sort, package, transport, and store clean linens in a manner that prevents risk of contamination by dust, debris, soiled linens or other soiled items. https://www.cdc.gov/hai/prevent/resource-limited/laundry.html 4. On 6/24/20 at 12:09 pm, housekeeping staff (E1) was exiting R6's room wearing gloves and holding a trash bag. E1 disposed the bag inside the cleaning cart. Still wearing the same gloves, E1 took the key from her pocket and unlocked the cart. E1 took a bottle of disinfectant spray and went back to R6's room. E1 exited the room and took the mop and the dustpan. E1 failed to remove her gloves and perform hand hygiene after exiting R6's room and before using the key to the cleaning cart. When E1 was asked when should she remove or change her gloves, E1 stated, I use one pair until I'm done in the room. During interview with the Assistant Director of Nursing (ADON) on 6/29/20 at 1:22 pm, when asked when if she expected staff to remove their gloves upon exiting the room, the ADON stated, Correct. Review of facility's undated policy titled Routine Handwashing and Sanitizing revealed, Purpose: To prevent the spread of infections. Handwashing/Sanitizing indications .before leaving a room. In a CDC article titled Guidance for the Selection and Use of Personal Protective Equipment (PPE) in Healthcare Settings dated 6/29/04 revealed under Gloves, Gloves protect you against contact with infectious materials. However, once contaminated, gloves can become a means for spreading infectious materials to yourself, other patients or environmental surfaces .Limit opportunities for touch contamination- protect yourself, others and environmental surfaces .Think about environmental surfaces too and avoid unnecessarily touching them with contaminated gloves. Surfaces such as light switches, door and cabinet knobs can become contaminated if touched by soiled gloves .Change gloves as needed. If gloves become torn or additional patient care tasks must be performed, then change the gloves before starting the next task .Perform hand hygiene immediately after removing PPE. https://www.cdc.gov/hai/pdfs/ppe/PPEslides6-29-04.pdf In a CDC article titled Core Concepts for Hand Hygiene: Clean Hands for Healthcare Personnel revealed, Bacteria can survive for days on patient care equipment and other surfaces like bed rails, IV pumps, etc. It is important to use hand hygiene after touching these surfaces and at exit, even if you only touched environmental surfaces. Under When Should You Clean Your Hands, 5. After touching surfaces around a patient. https://www.cdc.gov/infectioncontrol/pdf/strive/HH101-pdf https://www.cdc.gov/infectioncontrol/pdf/strive/HH101-