STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525445	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLUMBUS HEALTH AND REHAB	825 WESTERN AVE COLUMBUS, WI 53925

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 -** 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) ensure a nursing staff donned appropriate personal protective equipment (PPE) per Centers for Disease Control and Prevention (CDC's) recommendation when entering the room of one (R1) resident which the facility determined should be under monitoring due to possible exposure to COVID-19 during hospitalization ; (2) follow infection control practices when checking vital signs for two (R1 and R2) residents; (3) follow infection control practices related to the use of glucometer (medical device used to measure sugar levels in the blood) for one (R3) resident; (4) ensure proper placement of the urinary catheter collection bag to prevent urinary tract infection for one (R2) resident; and, (5) ensure clean linens were handled to prevent contamination for one (R4) resident and perform hand hygiene when delivering clean laundry for seven (R4, R5, R6, R7, R8, R9 and R10) residents. Findings include: 1. According to the Centers for Disease Control and Prevention, .Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE (which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown) . Review of the facility's undated New Admission COVID-19 Full Isolation List revealed that R1's admitted was 6/23/20. Further review of the same document revealed that the last day of full PPE (gloves, gown, eye protection and mask) was 7/7/20. Observation on 6/25/20 at 2:26pm revealed that a nursing assistant (NA1) went inside R1's room to assist R1 with toileting. NA1 was only wearing a mask. NA1 did not wear any eye protection nor did NA1 wear a gown before assisting R1 with toileting. Continuous observation revealed that a Licensed Practical Nurse (LPN1) went inside R1's room to bring iced water for R1 and noted that NA1 was not wearing full PPE. LPN1 then handed NA1 an isolation gown and a face shield as NA1 was in the washroom assisting R1 with toileting. In an interview with NA1 on 6/25/20 at 2:43pm, NA1 stated, I didn't know she (R1) left and came back. Last time I worked, she was off (isolation). When asked what PPE should she have put on before entering R1's room, NA1 stated, Gown, face shield, mask and gloves. In an interview with the Director of Nursing (DON) in the presence of the Administrator, the Infection Preventionist and the MDS (Minimum Data Set) Coordinator on 6/25/20 at 4:15pm, when told about the above observations, the DON stated, She was wrong, (she) should have (full) PPE on. Review of the facility's Procedure for Suspected COVID-19 Including ILI (influenza-like illness)/Acute Respiratory Status Changes dated 4/14/20 revealed .Resident will be placed in strict isolation precautions with PPE for any staff entering the resident's room. PPE: Gloves, gown, eye protection and N95 mask (if available) . 2. Review of the facility's undated New Admission COVID-19 Full Isolation List revealed that R1 and R2 were on full isolation (contact and droplet precautions) due to possible exposure to COVID-19 during hospitalization . Review of R1's current [DIAGNOSES REDACTED]. These conditions put R1 at increased risk of severe illness from COVID-19. Review of R2'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.) and dementia (condition which might put a person at an increased risk for severe illness from COVID-19). A. Observation on 6/25/20 at 3:24pm revealed that LPN2 went inside R2's room to check R2's vital signs. LPN2 sat her clipboard on R2's bed, without using any barrier to protect her clipboard from contamination by the surface of R2's bed, while checking R2's vital signs (blood pressure, temperature, pulse rate and oxygen saturation). LPN2 wiped the pulse oximeter (medical device used to measure pulse rate and oxygen saturation level) and the thermometer with an alcohol wipe but did not sanitize the blood pressure cuff. LPN2 put the pulse oximeter, thermometer and blood pressure cuff in the pocket of her scrubs. B. Continuous observation on 6/25/20 at 3:32pm revealed that LPN2 went to R1's room to check R1's vital signs. Without using any barrier to protect her clipboard from contamination by the surface of R1's over-bed table, LPN2 sat her clipboard on R1's over-bed table. After checking R1's vital signs, LPN2 wiped the thermometer and the pulse oximeter with an alcohol wipe but did not sanitize the blood pressure cuff after use with R1. LPN2 put the pulse oximeter, thermometer and blood pressure cuff in the pocket of her scrubs. In an interview with the DON in the presence of the Administrator, the Infection Preventionist and the MDS Coordinator on 6/25/20 at 4:23pm, when told about the above observations, the DON stated, (The clipboard) should not be (put) there (resident's bed and over-bed table). (It's) contaminated. The DON further stated, (The blood pressure cuff should be) sanitized in between (resident use). When asked about the observation of LPN2 putting the thermometer, pulse oximeter and blood pressure cuff in her pocket, the DON stated, She should not be putting them in the pocket. Review of the facility's Cleaning and Disinfection of Resident-Care Items and Equipment F880 last revised 11/2017 revealed under Policy Interpretation and Implementation, .d. Reusable items are cleaned and disinfected or sterilized between residents . 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 . 3. Review of R3'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.). Further review of the current [DIAGNOSES REDACTED]. Observation of LPN3 on 6/25/20 at 3:556pm, revealed LPN3 used the glucometer to check R3's blood sugar in R3's room. Without using any barrier to protect the lancet, blood glucose test strip case, glucometer case and glucometer from contamination by the surface of the medication cart, LPN3 sat the blood glucose testing machine and supplies on top of the medication cart. Without using any barrier to protect the gauze, lancet, blood glucose test strip case and glucometer from contamination by the surface of R3's over-bed table, LPN3 sat the blood glucose testing supplies and glucometer on R3's over-bed table. After checking R3's blood sugar, LPN3 went back to the medication cart and kept the glucometer in its case and put it inside the medication cart without sanitizing it. In an interview with the DON in the presence of the Administrator, the Infection Preventionist and the MDS Coordinator on 6/25/20 at 4:25pm, when told about the observation of nursing staff sitting the glucometer and blood glucose testing supplies on resident's over-bed table and medication cart without using any barrier, the DON stated, Barrier should be used (between surfaces and the glucometer and blood glucose testing supplies) and disinfect (the glucometer) after use. Review of the facility's Obtaining a Fingerstick Glucose Level policy and procedure dated 2/2020 revealed under Steps in the Procedure: .17. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control

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** - Some	(continued... from page 1) standards of practice . Further review of the same policy and procedure revealed that the policy did not address the use of barrier or liner for the glucometer to protect it from contamination from environmental surfaces. 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 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 . 4. Review of R2's list of Medical [DIAGNOSES REDACTED]. On 6/25/20 at approximately 12:30pm, the surveyor observed R2's urinary catheter collection bag was touching the floor. Observation on 6/25/20 at 1:30pm also revealed that R2's urinary catheter collection bag was laying on the floor. In another observation on 6/25/20 at 2:27pm and 3pm, R2's urinary catheter collection bag was still touching the floor. In an interview with the DON in the presence of the Administrator, the Infection Preventionist and the MDS Coordinator at 4:14pm on 6/25/20, the management staff was made aware of the surveyor's observation for which the DON stated, No, it (urinary catheter collection bag) should not touch the floor. Review of the facility's Indwelling Urinary Catheters F690 policy and procedure dated 1/2020 revealed under Infection Control, .2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag .b. Be sure the catheter tubing and drainage bag are kept off the floor . 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 101 under Table 6.2: Nursing Care to Prevent Infections with Indwelling Urinary Catheters, .8. Keep the collecting bag below the level of the bladder at all times. Do not place the bag on the floor (which was considered dirty and could be a source of infection) . 5.A. Observation on 6/25/20 at 12:55pm revealed a laundry staff (E1) was delivering clean laundry to R4's room and was holding them against her uniform. Review of R4's current [DIAGNOSES REDACTED]. In an interview with E1 on 6/25/20 at 1:10pm, when told about the observation of her holding the clean laundry against her uniform, E1 stated, I was afraid I was going to drop it. E1 agreed that the clean laundry should not be touching her uniform. In an interview with the DON in the presence of the Administrator, the Infection Preventionist and the MDS Coordinator on 6/25/20 at 4:08pm, when told about the observation of E1 holding clean laundry against her uniform, the DON stated, (The clean laundry) should not be touching her uniform. The DON further stated, Clean should not be touching the dirty (uniform could be potentially contaminated). Review of the facility's Handling of Clean Linen and Linen Distribution policy and procedure revised 6/2020 revealed under Policy Interpretation and Implementation, .3. Hold linen away from the uniform . According to the website www.hygienicallyclean.org in an article titled Handling Clean Linen in a Healthcare Environment published on 8/5/15, .It is especially important that clean HCTs (healthcare textiles) do not come in contact with an employee's uniform below the waist level. Many potentially contaminated surfaces are below waist level, such as beds, hampers, chairs and other furniture, making it more likely this part of the uniform could be contaminated . B. Observation of E1 on 6/25/20 at 12:55pm revealed that E1 was delivering clean laundry to R4's, R5's, R6's, R7's, R8's, R9's and R10's rooms. Further observation revealed that E1 entered the seven rooms to put clean laundry in the residents' dressers. E1 went in and out of the seven rooms without consistently performing hand hygiene in between resident rooms. In an interview with E1 on 6/25/20 at 1:10pm when asked if she should have performed hand hygiene in between resident rooms while delivering clean laundry, E1 stated, I should be (performing hand hygiene) in between rooms. Review of R4's and R5's current [DIAGNOSES REDACTED]. Review of the current [DIAGNOSES REDACTED]. Further review of R5's and R6's current [DIAGNOSES REDACTED]. Review of R8's current [DIAGNOSES REDACTED]. Review of R9's and R10's current [DIAGNOSES REDACTED]. Further review of R10's list of Medical [DIAGNOSES REDACTED]. In an interview with the DON in the presence of the Administrator, the Infection Preventionist and the MDS Coordinator on 6/25/20 at 4:08pm, 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 Handling of Clean Linen and Linen Distribution policy and procedure dated 6/2020 revealed under Policy Statement, Clean laundry .shall be handled in a manner that prevents gross microbial contamination of the .persons handling the linen. Further review of the same policy and procedure revealed under Policy Interpretation and Implementation, 1. Wash hands per hand hygiene protocol . Review of the facility's Handwashing/Hand Hygiene F880 policy and procedure last revised 3/2020 revealed under Policy Interpretation and Implementation, .6. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% [MEDICATION NAME] or [MEDICATION NAME] for all the following situations: .i. After contact with objects .in the immediate vicinity of the resident . According to the website www.hygienicallyclean.org in an article titled Handling Clean Linen in a Healthcare Environment published on 8/5/15, .As hygienically clean linen is distributed throughout a medical facility, staff members must take care that it remains as clean as when it was laundered. They must presume that linen storage covers, cabinets, door handles or anything they contact are contaminated. The article further indicated, Staff members should follow proper hand hygiene procedures and sanitize prior to handling healthcare textiles and after touching potentially contaminated surfaces .