STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525493	A. BUILDING _____ B. WING _____	05/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNRISE HEALTH SERVICES	3540 S 43RD ST MILWAUKEE, WI 53220

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** - Few	**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 use of glucometer (medical device used to measure sugar levels in the blood) for one (R1) resident; and, (2) ensure clean linens were handled to prevent contamination for two (R2 and R3) residents in the sample of three. Findings include: 1. Review of R1's current medical [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.). Observation of Licensed Practical Nurse (LPN)1, on 4/30/20 at 11:45am, revealed LPN1 used the Gluco Navii glucometer to check R1's blood sugar in R1's room. Without using any barrier to protect the glucometer and the glucose strips case from contamination by the surface of R1's over-bed table, LPN1 sat the glucometer and glucose strips case on R1's over-bed table. After checking R1's blood sugar, LPN1 administered R1's insulin via insulin pen and sat the insulin pen on R1's over-bed table. LPN1 went back to the medication cart positioned outside of R1's room and sat the contaminated glucometer, glucose strips case and insulin pen on top of the medication cart without using any barrier. LPN1 cleansed the glucometer using the Microdot bleach wipe by wiping the glucometer for approximately eight seconds. After wiping, the glucometer was observed to be completely dry within approximately five seconds. LPN1 put the glucometer in a small resealable bag and placed it in the top drawer of the medication cart. Without sanitizing the glucose strips case, LPN1 put it in the top drawer of the medication cart. LPN1 put the insulin pen in a resealable bag without sanitizing it and placed it inside the medication cart. In an interview with the Director of Nursing (DON) and Administrator on 4/30/20 at 3:06pm when told about the observation of nursing staff sitting the glucometer on top of the medication cart and resident's over-bed table without using any barrier, the Administrator just stated, The med (medication) carts and over-bed tables are being disinfected every day. When told that there was no observation of the LPN disinfecting the medication cart and the over-bed table before LPN1 performed the blood glucose monitoring, the DON stated, If those surfaces (medication cart and over-bed table) were sanitized then she could sit the glucometer on those surfaces. When asked how long was the contact time (length of time when a treated surface needed to be wet for effective disinfection) for Microdot Bleach wipes, the DON stated, Off the top of my head, I don't know. Review of the facility's Blood Sugar Monitoring policy and procedure, dated June 2017, revealed under Procedure, .4. Prepare the supplies: a. Open the wipe; b. Remove strip from bottle. Place strip on paper towel or tissue .21. Follow manufacturer's directions for use and care of the glucose meter. Review of the Links Medical Products' Cleaning & Disinfecting the Gluco Navii Blood Glucose Meter revealed under Gluco Navii Cleaning Guidelines: Use a lint free cloth dampened with soapy water or [MEDICATION NAME] (70% - 80%) to clean the outside of the blood glucose meter. Further review revealed under Gluco Navii Disinfecting Guidelines: 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 (do not saturate the towel0. 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 manufacturers .Please follow the disinfectant product label instructions to ensure proper drying time . Review of the Microdot Bleach Wipe Instructions for Use revealed, .3. Thoroughly wipe the .glucometer surface to be disinfected; 4. Wrap the .glucometer with the Microdot Bleach Wipe; 5. Place the wrapped .glucometer face down inside the .disinfection case; 6. Close disinfection case lid and activate timer: 3 minute(s) for microdot bleach wipe; 7. Allow the .glucometer to remain in contact with the bleach wipe for 3 minutes . 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 . 2. Review of R3's current [DIAGNOSES REDACTED]. Further review of R3's current medical [DIAGNOSES REDACTED]. A. Observation on 4/30/20 at 1:56pm revealed Nursing Assistant (NA1) was in the hallway handling a clean linen and an incontinence brief and was holding them against her uniform. NA1 went to R2's room. B. Observation on 4/30/20 at 2:05pm revealed NA1 was in the hallway handling clean linens and an incontinence brief and was holding them against her uniform. NA1 went to R3's room. In an interview with NA1 on 4/30/20 at 2:20pm, NA1 stated, I brought a brief and gown to (R2's) room and brought a brief, gown and chuck (bed or mattress) pad to (R3's) room. When asked if she should have held clean linens against her uniform, NA1 stated, We're not supposed to. When asked why she was not supposed to hold clean linens against her uniform, NA1 stated, Body contact (considered a contaminated surface), (with) germs (on her uniform) (was considered not following) infection control (practices). In an interview with the Administrator and the DON on 4/30/20 at 3:06pm, when told about the observations of NA1 holding clean linens against her uniform, the DON just stated, Okay. When told that NA1's uniform was considered contaminated, the Administrator and the DON did not respond. Review of the facility's undated Handling Clean Linen policy and procedure revealed under Purpose, To provide clean, fresh linen to each resident and prevent contamination of clean linen. Further review of the same policy revealed under Procedure, .3. The nursing staff places clean linen on the covered nursing cart to pass linen . The same policy also indicated under Important Points, Linen must remain covered at all times until it is placed on the resident's bed, towel rack or used with cares .Carry linen away from your body and uniform . According to an article titled, Best Practice Guidelines - Handling and Storing Clean Linen in Healthcare Facilities, .It is possible for linen to become contaminated without appearing visibly soiled .it is essential that every effort is taken to avoid inadvertent contamination prior to use. Contaminated linen can serve as a vector for drug resistant organisms and other harmful pathogens .It is the responsibility of everyone who handles clean linen or is responsible for its storage within the facility to ensure compliance to these guidelines within their department .Linen should be carried slightly away from the body to avoid cross-contamination .

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.