STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525330	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLA AT MIDDLETON VILLAGE (THE)	6201 ELMWOOD AVE MIDDLETON, WI 53562

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 did not maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases (such as COVID-19) for 3 of 6 residents reviewed (R1, R2, and R3) This has the potential to affect all 68 residents in the facility. The facility failed to ensure staff were using appropriate PPE (Personal Protective Equipment), specifically isolation gowns, when caring for residents (R1, R2 and R3) who tested positive for COVID-19 and in Transmission Based Precautions (TBP). The facility failed to ensure staff followed current standards of practice for donning and doffing (putting on/taking off) PPE to minimize transmission of pathogens (COVID-19). The facility did not appropriately disinfect shared vital sign equipment according to standards of practice. This is evidenced by: The facility's Infection Prevention and Control Interim Guideline for Suspected or Confirmed Coronavirus (COVID-19) updated 4/6/20, states in part: Full PPE should be worn per CDC (Center for Disease Control and Prevention) guidelines for the care of any residents with known or suspected COVID-19 per CDC guidance on conservation of PPE . Personal Protective Equipment and Supplies: .The facility will monitor necessary supplies and equipment . If facility is unable to obtain needed supplies and equipment from vendor, contact the local and state public health agency . PPE . Gowns: in the event of supply capacity concerns, see CDC Strategies for Optimizing the Supply of Isolation Gowns . The facility's Infection Prevention: Reusable Gown Cleaning Procedure dated 4/15/20 states in part: Purpose: During a period of PPE conservation, reusable gowns have been made available for use. Their material is durable enough to allow for cleaning and multiple uses . 1. Use Peroxide Multi Surface Cleaner and disinfectant 2. Apply solution to reusable gown evenly using a spray bottle or cloth 3. Allow a contact time of 2 minutes Resources: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cleaning-disinfection.html (Of note, this Resources reference from CDC does not address the cleaning or disinfection of a reusable gown for residents in TBP with a [DIAGNOSES REDACTED].Blood pressure cuffs When selecting an EPA registered disinfectant always follow: Contact times and label instructions .Protocol: At a minimum, noncritical patient-care devises are disinfected when visibly soiled and on a regular basis. (Of note, this policy does not describe the specific steps to follow, such as spraying and if to wipe surfaces with a clean cloth.) The facility stated that they follow current CDC guidelines: (website https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html) Strategies for Optimizing the Supply of Isolation Gowns, notes in part: . Contingency capacity: may change daily standard practices but may not have any significant impact on the care delivered to the patient or the safety of healthcare personnel (HCP). These practices may be used temporarily during periods of expected isolation gown shortages . Contingency Capacity Strategies: Selectively cancel elective and non-urgent procedures and appointments for which a gown is typically used by HCP. Shift gown use towards cloth isolation gowns. Reusable (i.e., washable) gowns are typically made of polyester or polyester-cotton fabrics. Gowns made of these fabrics can be safely laundered according to routine procedures and reused. Care should be taken to ensure that HCP do not touch outer surfaces of the gown during care . (Of note this guideline addresses cloth isolation gowns.) Findings: On 6/24/20 at 7:25 AM, Surveyor made general observations and noted that all staff were wearing masks, face shields or eye protection and isolation gowns as they moved through the facility. On 6/24/20 at entrance, NHA A (Nursing Home Administrator) reported to Surveyor that the facility had an outbreak of COVID-19 in May affecting 13 residents on one unit. Since then, 10 residents had tested negative for COVID-19, 2 of those residents had been discharged . NHA A stated 3 residents remained in droplet and contact precautions because they could not get 2 consecutive negative COVID-19 tests at least 48 hours apart. NHA A stated the facility had gone more than 28 days without any new cases of COVID-19. Example 1: R1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 5/15/20, in preparation for discharge to an Assisted Living Facility, R1 was tested for COVID-19. R1 tested positive for COVID-19 and was placed in Contact and Droplet Isolation Precautions. On 6/24/20 at 7:40 AM, Surveyor observed CNA D (Certified Nursing Assistant) outside of R1's room. CNA D completed hand hygiene with ABHS (alcohol based hand sanitizer) and placed a surgical mask over her N95 mask, applied ABHS, then removed the isolation gown she was wearing and hung it on a hook just outside of R1's door, applied ABHS then took out a clean yellow plastic raincoat (the package was labeled: Eva Raincoat) from the bottom drawer of the isolation cart and put it on. This raincoat snapped up the front, was long sleeved with elastic in the end of the sleeves. CNA D applied ABHS, a clean face shield from the top drawer of the isolation cart, applied ABHS and then gloves and entered R1's room. On 6/24/20 at 8:15 AM, Surveyor observed AD E (Activity Director) sitting in R1's room talking to R1. R1 was wearing a face mask. AD E was wearing a face shield, an N95 mask with a surgical mask over the N95 mask, gloves and a yellow plastic raincoat. On 6/24/20 at 8:35 AM, Surveyor observed AD E wearing the yellow raincoat, standing at the doorway of R1's room about to exit R1's room. AD E removed her gloves then applied ABHS to her hands, removed her face shield and set it on top of the isolation cart, AD E applied ABHS, removed the yellow raincoat and hung it on a hook outside of R1's door frame, just above the isolation cart located next to R1's room and applied ABHS to her hands. AD E reached into the bottom drawer of the isolation cart and removed a rolled up white isolation gown which was on top of clean yellow raincoats stored in the bottom drawer and put on the used gown. AD E then sprayed the face shield with disinfectant and rain coat with disinfectant spray. At that time, IDON B (Interim Director of Nursing) was coming down the hall and observed the yellow raincoat hanging on the hook outside of R1 door frame, while AD E was sanitizing her hands. IDON B stated AD E should have had the face shield and yellow raincoat inside the room to disinfect them. IDON B stated to Surveyor that AD E was new and that she would get AD E a new gown, re-educate her, and make sure all items on the isolation cart were replaced. Later IDON B came to Surveyor and said that AD E did deviate for the proper protocol for removing PPE and removed all items from the isolation cart and disinfected everything. IDON did provide documentation that AD E had received PPE training at hire. Example 2: R2 was admitted to the facility on [DATE] with Acute [MEDICAL CONDITION]. R2 tested positive for COVID-19 on 5/13/20 and placed on droplet and contact precautions. On 6/24/20 at 7:30 AM, Surveyor observed packaged yellow raincoats in the bottom of the isolation cart outside of R2's room. Example 3: R3 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. R3 tested positive for COVID-19 on 5/15/20 and placed on droplet and contact precautions. On 6/24/20 at 7:30 AM, Surveyor observed packaged yellow raincoats in the bottom of the isolation cart outside of R3's room. On 6/24/20 at 2:30 PM Surveyor interviewed NHA A and ICN C about PPE supplies at the facility. Surveyor asked if the facility had a shortage of isolation gowns. NHA A stated we have no shortage if you consider ponchos and raincoats. NHA A stated we started using regular isolation gowns for residents in isolation, but my understanding is our vendors had isolation gowns on back order and we were going to other options. NHA A stated her corporation was tracking facility PPE use. NHA A stated that she had contacted the State Emergency PPE Stock pile every 2 weeks, and had received items in May and June. Surveyor requested any documentation the facility had on tracking their PPE supplies, contacts with vendors and ordering of PPE. Example 4 On 6/24/20 at 8:45 AM, Surveyor observed a vital sign cart in the hall with a washcloth sitting in the basket on top of 2 blood pressure cuffs. The wash cloth had yellow substance soaked into the material that appeared to be the same color as the facility's bottle of disinfectant. Surveyor pointed out the used washcloth on top of the blood

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) pressure cuffs to IDON B who stated staff should be using a new cloth between each use on a resident. IDON B stated I will get this corrected. Surveyor requested the facility's policy on disinfecting shared items. On 6/24/20 at 8:50 AM, Surveyor interviewed CNA D and asked if she had used the vital sign cart that morning. CNA D stated that she had taken vital signs on 2 residents earlier (residents were not in precautions) and used the same wash cloth to wipe down the machine and blood pressure cuffs between each patient. CNA D said the items had 2 minutes of contact time of the disinfectant with each use before wiping down. Surveyor asked ICN C when the facility had identified positives cases of COVID-19, if she had informed public health of the facility's shortage of isolation gowns, ICN C said she talked to public health and reported that they had N-95 masks and face shields. Surveyor asked if ICN C had asked public health about using raincoats in place of isolation gowns for residents in isolation for COVID-19, ICN C stated she was not sure, she might have said they were using reusable gowns. Surveyor asked ICN C if it was appropriate to use raincoats as isolation gowns for residents in isolation precautions. ICN C stated a reusable gown is something you disinfect and use again. Surveyor requested any documentation or evidenced-based practice that the facility had on staff reusing isolation gowns, the facility provided Infection Prevention: Reusable Gown Cleaning Procedure dated 4/15/20, no further information was received. On 6/25/20, at 9:23 AM, NHA A provided documentation that the facility received deliveries of PPE on 5/18/20, (no gowns, 100 coveralls), 6/1/20 (no gowns, 145 coveralls), 6/12/20 (20 gowns). NHA A reported to Surveyor that the facility had 105 disposable isolation gowns and 80 blue plastic gowns in stock. On 6/25/20 at 1:13 PM, Surveyor interviewed PHN F (Public Health Nurse) about the facility's reporting of COVID cases and the facility outbreak of COVID-19 on 5/13/20. PHN F stated the facility had been reporting cases of COVID-19 appropriately and following recommendations. Surveyor asked PHN F if the facility had reported to PHN F that they had shortages of isolation gowns. PHN F was not aware of the facility having a shortage of gowns. Surveyor asked PHN F if he was aware that the facility was using raincoats as a replacement for isolation gowns, for residents placed in TBP for COVID-19, and staff was spraying the raincoats with disinfectant between uses. PHN F stated he was not aware of this practice by the facility, the facility did not tell PHN F of this practice. PHN F stated a raincoat is not an isolation gown and there is no evidenced-based information this would be appropriate use. PHN F stated there could be a concern of vector transmission of COVID-19 virus to the staff when they tried to re-use the raincoat. The facility failed to ensure staff were using approved PPE when caring for residents in droplet and contact precautions for COVID-19, which could result in cross contamination of staff. Staff did not remove PPE to prevent cross contamination to the environment, isolations supplies or others. Staff were not disinfecting shared vital sign equipment appropriately which could lead to cross contamination of germs to residents.