STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525462	A. BUILDING _____ B. WING _____	**06/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAPLEWOOD OF SAUK PRAIRIE	**245 SYCAMORE ST SAUK CITY, WI 53583**

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 -** 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: disinfect shared sit-to-stand mechanical lifts and slings between residents use; and maintain the integrity of sit-to-stand mechanical lift padding to ensure proper disinfection was attainable. The facility's failure resulted in a risk of infection transmission, including COVID-19, for 14 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, and R14) that used the sit to stand mechanical lifts. Findings include: At the time of the survey the facility had no confirmed COVID-19 positive staff or residents. Observation on 6/22/20 at 3:44 pm, in the hall outside of room [ROOM NUMBER], revealed a sit to stand mechanical lift (a device used to assist residents with transferring from one surface to another) with a three inch tear in the knee rest padding exposing the paddings inner foam. During a follow-up interview on 6/22/20 at 3:47pm, with the Nursing Assistant (NA1), NA1 confirmed that the sit to stand lift and the sling are shared by multiple residents. When asked about how the sit to stand lift and the sling are disinfected between residents, NA1 stated that the handles of the machine are cleaned with a sanitizer wipe. When asked if the knee padding was wiped with the sanitizer between residents, NA1 stated, I would say no. NA1 also verified that the tear in the knee padding and the exposed foam would prevent the knee padding from being properly disinfected. When asked how the sling is cleaned between residents, NA1 stated, I'm not sure the cleaning process for that or if there is one. NA1 then confirmed that the sling had been used by R1 and R2 without being disinfected between residents. Observation on 6/22/20 at 4:01 pm, in the hall outside of room [ROOM NUMBER], revealed a second sit to stand mechanical lift with two tears in the knee rest padding. Observation on 6/22/20 at 4:05 pm, in the hall outside of room [ROOM NUMBER], revealed a third sit to stand lift with one handle wrapped in mesh and tape. During a follow-up interview on 6/22/20 at 4:06 pm, with NA2, NA2 confirmed that the sit to stand lift with the wrapped handle was used by multiple residents and the mesh and tape was on the handle to help resident's grip. When asked how the sit to stand lift is disinfected between residents. NA2 stated that the only time the sit to stand is disinfected is when it is used with a resident on isolation precautions. When asked if the permeable mesh and tape on the handle could be properly disinfected between residents, NA2 stated, Do I need to take it off? I can take it off. During an interview on 6/23/20 at 12:50 pm with the Director of Nursing (DON) and the Infection Preventionist, when asked about the expectations for disinfecting of the sit to stand lift and sling between residents, the DON and Infection Preventionist confirmed that the staff should be wiping the sit to stand lift and the sling with the disinfectant wipes after every use. When asked if the sit to stand lift could be properly disinfected if there are tears in the knee rest padding, the DON stated, I would say no. During follow-up observations of sit to stand lifts and slings in the facility, on 6/23/20 from 12:55 pm to 1:06 pm, with the DON and Infection Preventionist, the DON and Infection Preventionist identified four slings with a permeable fabric that would not be able to be disinfected between residents. The DON and Infection Preventionist also identified three sit to stand lifts with tears in the knee rest padding. Review of the facility provided list of residents revealed that 14 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, and R14) in the facility used the sit to stand lifts. Review of the facility's Disinfecting Reusable or Multi-Resident Use Items Policy and Procedure, dated 8/24/10, revealed, Each resident uses various items which can be reused or are used by other residents. These items may include wash basins, bedpans, commodes, hats, mechanical lifts, etc. These items will be cleaned routinely and/or between uses as appropriate, in order to maintain proper infection control principles .Items such as commodes and mechanical lifts should be disinfected after each use, with disinfectant spray or wipes, which are provided . According to the Centers for Disease Control (CDC), Guideline for Disinfection and Sterilization in Healthcare Facilities (2008), .Inspect equipment surfaces for breaks in integrity that would impair either cleaning or disinfection/sterilization. Discard or repair equipment that no longer functions as intended or cannot be properly cleaned, and disinfected or sterilized .Disinfect noncritical medical devices (e.g., blood pressure cuff) with an EPA-registered hospital disinfectant using the label's safety precautions and use directions .Ensure that, at a minimum, noncritical patient-care devices are disinfected when visibly soiled and on a regular basis (such as after use on each patient or once daily or once weekly) .

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