STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525726	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEVIEW HEALTH CENTER	962 E GARLAND ST E WEST SALEM, WI 54669

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 the unprecedented coronavirus global pandemic that resulted in the Presidential declaration of a State of National Emergency dated 3/13/20, The Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Memo QSO-20-14-NH revised on 3/13/20, Nursing Home guidance from the Centers for Disease Control and Prevention (CDC), observation, interview, and record review, the facility failed to ensure adherence to infection control practices to prevent the transmission of the Coronavirus (COVID-19) as evidenced by failure to: properly disinfect shared medical equipment after each use; adhere to social distancing; perform hand hygiene and utilize gloves properly; and proper handling of linen. Findings include: 1. A. Review of R1's medical record revealed [DIAGNOSES REDACTED]. On 6/23/20 at 11:41am, Registered Nurse1 (RN1) was observed during provision of care to R1. RN1 checked R1's blood pressure, temperature and oxygen saturation level (oxygen level in the blood). After the procedure, RN1 wiped the pulse oximeter (device that measures the amount of oxygen in the blood) using one small alcohol pad for five seconds and using the same alcohol pad, RN1 wiped the(NAME)digital thermometer for six seconds. RN1 then placed the pulse oximeter and the thermometer back in the storage basket and disposed the wipe. RN1 took one Hydrogen Peroxide wipe (disinfecting wipe) and wiped the blood pressure cuff for 10 seconds. Surveyor used the stopwatch app from the computer. RN1 failed to observe the equipment to ensure that it remained wet for the recommended contact time. When asked how long should the wet or contact time be for the blood pressure cuff using the Hydrogen Peroxide disinfecting wipe, RN1 was unsure and looked at the label of the disinfecting wipes. RN1 then stated 30 seconds. RN1 further stated that sometimes she would use the alcohol pad and other times she would use the Hydrogen Peroxide wipes. B. Review of R2's medical record revealed [DIAGNOSES REDACTED]. sounds using the stethoscope (medical device used to listen to the heart and lung sounds). After the procedure, RN2 wiped the pulse oximeter using one Clorox Hydrogen Peroxide wipe for six seconds, wiped the digital thermometer for five seconds and returned both items in the storage basket. Using the same wipe, RN2 wiped the stethoscope for seven seconds. Surveyor used the stopwatch app from the computer. RN2 failed to observe the equipment to ensure that it remained wet for the recommended contact time. C. Review of R3's medical record revealed [DIAGNOSES REDACTED]. On 6/23/20 at 2:57pm, RN2 was observed checking R3's oxygen saturation level, temperature and assessed R3's lung sounds using the stethoscope. After the procedure, RN wiped the pulse oximeter for 10 seconds using one Clorox Hydrogen Peroxide wipe. Using the same wipe, RN2 wiped the digital thermometer for seven seconds and the stethoscope for 10 seconds. Surveyor used the stopwatch app from the computer. RN2 failed to observe the equipment to ensure that it remained wet for the recommended contact time. When asked how long should the wet time or contact time be, RN2 checked the label and stated, 30 seconds. During interview with the Director of Nursing (DON) on 7/8/20 at 9:20am, when asked about her expectation from staff to ensure that shared medical equipment are exposed to the disinfectant for the required contact time, the DON stated, If we use it on one resident, that we clean it before using it on another resident. They need to clean it with disinfectant before going to another resident. They do not need to scrub it for 30 seconds per manufacturer, they do need to wipe it because it says contact for 30 seconds. Review of facility's policy titled Standard Precautions (IC) dated 3/26/20 revealed under Resident Care Equipment, it revealed, Clean and disinfect non-disposable and multi-use equipment before use on another person. Review of the Clorox Hydrogen Peroxide Portfolio Overview revealed, Kill bacteria [MEDICAL CONDITION] in as fast as 30 seconds with the power of hydrogen peroxide. Under Usage, it revealed, Directions .To clean and disinfect hard, nonporous surfaces: Wipe surface until completely wet. Allow surface to remain wet for contact time listed on label. Let air-dry. For heavily soiled areas, pre-cleaning is required. https://www.cloroxpro.com/products/clorox/hydrogen-peroxide-disinfecting-cleaners/ Review of the Clorox Hydrogen Peroxide Directions for use video revealed, Keep surface visibly wet for the required contact time. You may dry the surface after the contact time has been reached. Recap: Put on PPE. Remove Soil (clean). Wipe surface (disinfect). Wait (contact time). Discard wipe. https://www.cloroxpro.com/products/clorox-healthcare/hydrogen-peroxide-cleaner-disinfectants/?gclid=EAIaIQobChMIvIeC84id6gIVE77ACh0kZANcEAAYASAAEgLAT_D_BwE&gclsrc=aw.ds In a CDC article titled Factors affecting the Efficacy of Disinfection and Sterilization dated [DATE] revealed, The activity of germicides against microorganisms depends on a number of factors, some of which are [MEDICATION NAME] qualities of the organism, others of which are the chemical and external physical environment. Awareness of these factors should lead to better use of disinfection and sterilization processes. Under Duration of Exposure, it revealed, Items must be exposed to the germicide for the appropriate minimum contact time. Multiple investigators have demonstrated the effectiveness of low-level disinfectants against vegetative bacteria (e.g., Listeria, E. coli, Salmonella, VRE,[MEDICAL CONDITION]), yeasts (e.g., Candida), mycobacteria (e.g., M. [MEDICAL CONDITION]), [MEDICAL CONDITION] (e.g., [MEDICATION NAME]) at exposure times of 30-60 seconds. By law, all applicable label instructions on EPA-registered products must be followed. https://www.cdc.gov/infectioncontrol/guidelines/disinfection/efficacy.html 2. Review of R4's record revealed [DIAGNOSES REDACTED]. mellitus (chronic disease characterized by high levels of sugar in the blood). Review of R5's medical record revealed [DIAGNOSES REDACTED]. This makes it hard to breathe and causes wheezing), and unspecified asthma (airways become blocked or narrowed causing breathing difficulty). On 6/23/20 at 12:12pm, while inside the Cedar Lane Unit, R4 was observed sitting in the same table with R5. R4 was sitting across from R5 while they ate lunch. The distance between R4 and R5 was less than six feet. The table was approximately four feet by four feet in size. R4 sniffled several times and R5 coughed three times but R5 covered her mouth while R4 continued to eat his lunch. There were staff present in the dining area, but the staff failed to remind both residents on social distancing and for R5 to perform hand hygiene after coughing. Licensed Practical Nurse1 (LPN1) stated that R4 and R5 preferred to sit in the same table and that both residents refused to move to another table. There was no documentation under progress notes on both residents from May 2020 to present that they have attempted to remind both residents on social distancing. During interview with the Director of Nursing (DON) on 7/8/20 at 9:20am, when asked about her expectation from staff when they see two residents seated in the same table, the DON stated, So we do ask that they (staff) ask residents to move, to check their care plan and see. If we are talking about two residents that can seat together, the risks and benefits have been done with the residents' representative or guardian. Even with the pandemic, residents have the right to choose. Our plan is one resident per table. Review of facility's policy titled Pandemic Plan - COVID-19 (IC) dated 6/19/20 revealed under Resident Dining Plan, 1. All residents must remain an appropriate social distancing space apart (at least 6 ft) at meals. 2. No more than one resident per table. In a CDC article titled Preparing for COVID-19 in Nursing Homes dated June 25, 2020, revealed under Core Practices, Implement Social Distancing Measures. Implement aggressive social distancing measures (remaining at least 6 feet apart from others): Cancel communal dining .Remind residents to practice social distancing, wear a face cloth covering (if tolerated), and perform hand hygiene . https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html 3. A. On 6/23/20 at 11:56am, Culinary Service Assistant (E1) was observed lifting the lids of the food storage containers for lunch. E1 was wearing face mask and a face shield. E1 was observed touching her face mask with both hands. E1 failed to perform hand hygiene. E1 proceeded to

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) touch the lids and removed the plastic covers from the steel containers. E1 failed to perform hand hygiene after touching her facemask. When asked what she missed, E1 stated she did not wash her hands. B. On 6/23/20 at 12:09pm, while in the kitchen area of the Northwood unit, Certified Nursing Assistant1 (NA1) was observed pouring juice in cups. NA1 paused and lifted the bottom part of her facemask for a few seconds. NA1 proceeded to pour more juice in cups. NA1 failed to perform hand hygiene after touching her facemask. During interview with the DON on 7/8/20 at 9:20am, when asked about her expectation from staff after touching their facemasks, the DON stated, I expect them to use a hand sanitizer or wash their hands. When asked if she thought this was important especially when setting up for lunch and preparing drinks for the residents, the DON further stated, Yes. I do. Review of facility's policy titled, Infection Control Standards (IC) dated 2/19/20 did not reveal any documentation to perform hand hygiene after contact with gloves or other personal protective equipment. In a CDC article titled Facemask Do's and Don'ts for Healthcare Personnel dated June 2, 2020 revealed, When wearing a face mask, don't do the following, DON'T touch or adjust your facemask without cleaning your hands before and after . https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/fs-facemask-dos-donts.pdf 4. A. On 6/23/20 at 11:32am, NA2 was observed pushing the Volaro hoyer lift (device used to assist healthcare personnel with safe patient transfers and handling) in the hallway. NA2 exited R9's room wearing gloves, held the soiled linen and sling on her left gloved hand while pushing the hoyer lift. NA2 parked the hoyer lift in the storage area. NA2 went to room [ROOM NUMBER] and disposed the soiled underpad and sling. NA2 exited the room with a blanket and proceeded to walk towards the laundry room. Still wearing gloves, NA2 opened the laundry room using a key which she took from her pocket. NA2 opened the door to the washing machine, placed the blanket inside and turned the setting knob on. While in the laundry room, NA2 removed her gloves and immediately lifted her goggles. NA2 failed to perform hand hygiene immediately after glove removal and before touching her goggles. NA2 paused for several seconds, took a few breaths, then walked to the sink to wash her hands. When asked if she could wear gloves in the hallway, NA2 stated, I changed my gloves before leaving the room (R9's room). When asked if she could carry loose soiled linen out of the room, without a bag, NA2 further stated that the R9 had a bowel movement and she cleaned the resident. NA2 further stated, I didn't have a bag to put the linens in. I should. During interview DON on 7/8/20 at 9:20am, when asked about her expectation from staff when carrying soiled linen from a resident's room, The DON stated, They should be bagged. When asked what staff should do after glove removal and before touching knobs or other equipment, the DON stated, They should take their soiled gloves off and wash their hands. Review of facility's policy titled Infection Control Standards (IC) dated 2/19/20 revealed under hand hygiene and glove use, Staff should NOT be wearing gloves in common areas such as hallways and the Dining areas. Under Guidelines for Hand Washing and Hand Antisepsis, it revealed, Decontaminate means using an alcohol-based rub .Decontaminate hands after removing gloves. Under handling soiled linen, it revealed, Obtain clean clear plastic bag prior to changing soiled linen .Place soiled linen immediately into bag for transport to dirty linen room .DO NOT carry soiled linens or soiled incontinence products across common areas. Remove gloves. Perform hand hygiene. Review of facility's policy titled Exposure Control Plan - Bloodborne Pathogens revealed under Personal Protective Equipment (PPE), All employees using PPE will follow these requirements: hand hygiene is performed immediately or as soon as possible after removal of gloves or other PPE. Review of facility's policy titled Soiled Linen Handling dated 8/28/19 revealed under Procedure, 2. Distribute soiled linens and clothing to container utilizing wheeled cart or garbage bag for transport .7. For personal laundry soiled with blood/body fluids .place soiled linen in yellow biohazard bag and transport to the laundry room for immediate washing. In a CDC article titled Personal Protective Equipment: Questions and Answers dated March 14, 2020, revealed, It is important for HCP to perform hand hygiene after removing PPE. Hand hygiene should be performed by using an alcohol-based hand sanitizer that contains 60-95% alcohol or washing hands with soap and water for at least 20 seconds. https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirator-use-faq.html#Gloves In a CDC article titled Appendix D - Linen and laundry management dated March 27, 2020 revealed, Place soiled linen into a clearly labeled, leak-proof container (e.g., bag, bucket) in the patient care area. Do not transport soiled linen by hand outside the specific patient care area from where it was removed. https://www.cdc.gov/hai/prevent/resource-limited/laundry.html In a CDC power point presentation titled Guidance for the Selection and Use of Personal Protective Equipment (PPE) in Healthcare Settings revealed under Do's and Don'ts of Glove Use, Limit opportunities for touch contamination - protect yourself, others, and the environment .Don't touch environmental surfaces except as necessary during patient care. 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. Therefore, the way you use gloves can influence the risk of disease transmission in your healthcare setting .Limit opportunities for touch contamination - protect yourself, others and environmental surfaces. How many times have you seen someone adjust their glasses, rub their nose or touch their face with gloves that have been in contact with a patient? This is one example of touch contamination that can potentially expose oneself to infectious agents. 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. Under Key Points about PPE, it revealed, Use carefully - don't spread contamination. Remove and discard carefully, either at the doorway or immediately outside patient room .immediately perform hand hygiene. Under Hand Hygiene, it revealed, Hand hygiene is the cornerstone of preventing infection transmission. You should perform hand hygiene immediately after removing PPE. https://www.cdc.gov/HAI/pdfs/ppe/PPEslides6-29-04.pdf B. On 6/23/20 at 11:39am, NA1 was observed coming out of the laundry room carrying a clean, printed blanket, without a covering. NA1 was holding the blanket to her side, touching her body and was touching her scrub top. NA1 brought the blanket to R8's room. When asked how should staff carry clean linen, NA1 stated, Carrying it away like that while showing surveyor how clean linen should be held away from the body. During interview with the DON on 7/8/20 at 9:20am, when asked about her expectation from staff when carrying clean linen, the DON stated, Away from their scrubs. Review of facility's policy titled Infection Control Standards (IC) dated 2/19/20, did not reveal any documentation on handling clean linens. In a CDC article titled Appendix D - Linen and laundry management dated March 27, 2020, revealed under Best practices for management of clean linen, 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