STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525282	A. BUILDING _____ B. WING _____	04/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CROSSROADS CARE CENTER OF KENOSHA	8633 32ND AVE KENOSHA, WI 53142

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 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 two (R1 and R2) residents; (2) ensure that pulse oximeter (medical device used to measure pulse and oxygen saturation level) shared among residents was properly cleaned and disinfected after resident use for one (R3) resident; (3) perform hand hygiene when delivering clean laundry for 13 (R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15 and R16) residents; and, (4) perform hand hygiene when appropriate while assisting residents during meal for four (R3, R11, R12 and R17) residents. Staff failures to disinfect shared medical equipment, handle medical equipment to prevent contamination, perform hand hygiene while delivering clean laundry and assisting residents during meal had the potential to affect residents residing on three units (Wing 1, Wing 2 and Wing 5) of the facility. Findings include: 1. Review of R1's and R2's current care plans revealed that they had [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]. A. Observation of Registered Nurse (RN)1, on 4/21/20 at 11:16am, revealed RN1 used the glucometer shared among residents 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 the table, RN1 sat the glucometer and the glucose strips case on R1's over-bed table. RN1 went back to the medication cart positioned across the nurses' station after the procedure and sat the contaminated glucometer and glucose strips case on top of the medication cart without using any barrier. RN1 cleansed the glucometer using the PDI Sani-Cloth Plus by wiping the glucometer for approximately four seconds. After wiping, the glucometer was observed to be completely dry within approximately five seconds. B. Observation of RN2 on 4/21/20 at 12:29pm, revealed RN2 used the glucometer shared among residents to check R2's blood sugar in her room. Without using any barrier to protect the glucometer from contamination by the surface of the table, RN2 sat the glucometer on R2's over-bed table. RN2 had an error message on the glucometer and had to get another glucose strip and lancet from the medication cart. RN2 went back to the medication cart positioned by the nurses' station and sat the contaminated glucometer on top of the medication cart without using any barrier. RN2 went back to R2's room to recheck R2's blood sugar and sat the contaminated glucometer on R2's over-bed table. In an interview with the Director of Nursing (DON) on 4/21/20 at 3:08pm when told about the observation of nursing staff sitting the glucometer on residents' over-bed tables without using any barrier, the DON stated, (Nursing staff should) use a barrier with glucometer on the table and medication cart. When asked how long was the contact time (length of time when a treated surface needed to be wet for effective disinfection) for PDI Sani-Cloth Plus, the DON stated, Three minutes. According to the PDI Sani-Cloth Plus Germicidal Disposable Cloth General Guideline For Use, .3b. Unfold a clean wipe and thoroughly wet surface. 4. Allow treated surface to remain wet for three (3) minutes. Let air dry . Review of the facility's undated Cleaning and Disinfecting Blood Glucose Meters revealed under Procedure: .4. When at the bedside, place a barrier (such as a paper towel) between the blood glucose meter and surface - if setting meter down .11. In the absence of manufacturer's recommendations, the glucometer is considered a semi-critical device, follow policy for cleaning semi-critical devices . 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. Observation of RN3, on 4/21/20 at 1:10pm, revealed RN3 used the pulse oximeter to check R3's oxygen saturation level in R3's room. After using the pulse oximeter, RN3 wiped the pulse oximeter with the PDI Sani-Cloth Plus for approximately five seconds and put it back in the vital signs machine/cart. After wiping, the pulse oximeter was observed to be completely dry within approximately five seconds. In an interview with the DON on 4/21/20 at 3:08pm, when told about the observations of nursing staff not appropriately sanitizing the pulse oximeter after resident use, the DON stated, The disinfection of the pulse oximeter follows the same contact time of three minutes with the use of the PDI Sani-Cloth Plus. According to the PDI Sani-Cloth Plus Germicidal Disposable Cloth General Guideline For Use, .3b. Unfold a clean wipe and thoroughly wet surface. 4. Allow treated surface to remain wet for three (3) minutes. Let air dry . Review of the facility's Infection Prevention and Control Manual dated 2019 revealed under Resident-care equipment and instruments/devices, .c. Organic material will be removed from critical and semi-critical instrument/devices, using recommended cleaning agents before disinfection and sterilization to enable effective disinfection and sterilization processes . 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. Observation of a laundry staff (E1) on 4/21/20 at 11:33am revealed that E1 was delivering clean laundry to R4's, R5's, R6's, R7's, R8's, R9's, R10's, R11's, R12's, R13's, R14's, R15's and R16's rooms. E1 was delivering the clean laundry using a cart that was not covered. Further observation revealed that E1 was wearing gloves and mask. Wearing the same pair of gloves, E1 entered the 13 rooms to put clean laundry in the residents' closet. E1 went in and out of the 13 rooms without doing hand hygiene and changing her gloves. In an interview with E1 on 4/21/20 at 11:52am when asked if she should have performed hand hygiene and donned new pair of gloves in between resident rooms while delivering clean laundry, E1 stated, I wash my hands before and after distributing laundry to all the rooms. We should do that (perform hand hygiene and don new pair of gloves in between resident rooms) all the time but I did not do it. When asked if the clean laundry should have been covered during transport to the residents' rooms, E1 stated, I never had to do that. Review of R4's, R5's, R6's, R8's, R9's, R14's and R16'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 R6's, R9's and R16's current [DIAGNOSES REDACTED]. Review of R15's current [DIAGNOSES REDACTED]. This put the person at risk for serious infections.). In an interview with the Administrator and the DON on 4/21/20 at 3:08pm, when asked of their expectations of laundry staff when delivering clean laundry to residents' rooms, the Administrator stated, (Laundry staff) should be washing their hands between resident rooms when delivering laundry. When

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) told about the linen cart not being covered as E1 was delivering clean linens, the Administrator stated, It should be covered. Review of the facility's Handling Clean Linen policy and procedure dated 1/20/20 revealed under Procedure, 1. Clean linen is transported from the laundry to the linen room in a clean, covered cart with a solid bottom . Further review of the same policy and procedure revealed under Important Points, Linen is covered during transport to prevent contamination while being moved through the facility . Review of the facility's Hand Washing policy and procedure dated 1/8/01 revealed under Policy: .The absolute indications for and the ideal frequency are not know. However, in the absence of a true emergency, personnel should always wash their hands (even when gloves are worn): .After situations in which microbial contamination of hands is likely to occur; After touching inanimate objects that are likely to be contaminated with virulent or epidemiological important microorganisms .When otherwise indicated to avoid transfer or microorganisms to other residents and environments .gloves are not a substitute for hand washing. Hands should be washed as indicated above even when gloves are worn . 4. Observation on 4/21/20 at 12:43pm revealed that RN3 was supervising and assisting four residents in the Wing 1 dining room. RN3 opened the milk carton for R11 and without doing hand hygiene, RN3 went to R12's table to fix R12's clothing protector and assisted R12 with feeding. Without performing hand hygiene, RN3 went to R17's table to put R17's can of soda within her reach. RN3 then used a hand sanitizer, don gloves and went back to R12's table to assist R12 with feeding. While wearing the same gloves, RN3 went to R3's table as she was coaching R3 to do two swallows. RN3's gloved hands were resting on R3's table as she was coaching R3. RN3 went back to R12's table to assist R12 with feeding. As another staff member came to assist R12 with feeding, RN3 then removed her gloves and without doing hand hygiene, RN3 went to R11's table to check on R11. RN3's hands were resting on R11's table as she was checking on her. In an interview with the DON on 4/21/20 at 3:08pm, when told about the observations of lapses in hand hygiene by RN3 while supervising and assisting the residents in the dining room, the DON stated, (She should do) hand hygiene in between residents when assisting with meals. Review of the facility's Hand Washing policy and procedure, dated 1/8/01, revealed under Policy: Because hand washing is generally considered the most important single procedure for preventing nosocomial infections, it is important that proper procedures be followed. All staff are required to wash their hands after each direct or indirect contact for which hand washing is indicated by accepted professional practices .The absolute indications for and the ideal frequency are not known. However, in the absence of a true emergency, personnel should always wash their hands (even when gloves are worn): .As promptly and thoroughly as possible after contact with blood, body fluids, secretions, excretions and equipment and articles contaminated by them, whether or not gloves are worn; After gloves are removed .After situations in which microbial contamination of hands is likely to occur; After touching inanimate objects that are likely to be contaminated with virulent or epidemiological important microorganisms; As promptly and thoroughly as possible between resident contact; When otherwise indicated to avoid transfer of microorganisms to other residents and environments . Further review of the Hand Washing policy and procedure revealed under Procedure: .gloves are not a substitute for hand washing. Hands should be washed as indicated above even when gloves are worn .