STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525398	A. BUILDING _____ B. WING _____	05/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRESCOTT NURSING AND REHAB COMMUNITY	1505 ORRIN RD PRESCOTT, WI 54021

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 failed to implement a physician's order for contact and droplet isolation for one resident (Resident (R) 1) who exhibited an elevated temperature, a symptom of COVID-19. The results of the resident's COVID-19 test were not available until five days after the resident had an elevated temperature. The resident was not placed in contact and droplet isolation as ordered by the Nurse Practitioner pending the results of the COVID-19 test. This failure to isolate a potentially positive COVID-19 resident and prevent the spread of [MEDICAL CONDITION] had the potential to affect all 40 residents who resided in the facility at the time of the survey. Findings include: The Face Sheet, located in R1's electronic health record (EHR), indicated he had been admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A care plan, dated 03/18/20, located in the Care Plan tab of the EHR, documented R1 was at risk of contracting COVID-19. Approaches to the problem included: If resident is ill, follow facility infection control policies to reduce/contain the spread of infection. Place resident on Droplet precautions if displaying symptoms of COVID-19 (fever, cough, soar (sic) throat, Shortness of breath, respiratory conditions). The quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 04/12/20, documented R1's Brief Interview for Mental Status score was 07, which indicated he had severe cognitive impairment. The MDS indicated R1 required extensive assistance with most activities of daily living and received no special treatments, procedures or programs. A physician's order for R1, dated 05/16/20 at 6:01 PM, was provided by the Administrator. The order documented: .Covid19 swab.Droplet and contact isolation. and was written by Licensed Practical Nurse (LPN) 10. A nurse's progress note, dated 05/16/20 at 7:04 PM, written by LPN10, located in the Progress Notes tab of the EHR, documented: Writer went into Residents room and noted Resident (R1) breathing fast and rubbing his chest with both hands. Resident did not c/o (complain of) chest pain but did get relief from PRN (as needed) TUMS.(NP9) ordered.COVID swab.Droplet and contact isolation.Resident moved to D (wing) after supper. R1's temperature log, found in the Vital Signs tab in the EHR, documented R1 had a temperature of 101.3 degrees Fahrenheit (F) on 05/16/20 at 7:22 PM. A care plan, dated 05/21/20, documented R1 had a problem identified as: positive or exhibiting signs and symptoms of COVID-19 infection. I am febrile starting 5/16/20 and was placed in isolation per COVID-19 policy. Approaches to the problem included: Educate staff on infection control measures and Quarantine per facility policy and availability of room in the facility. The COVID-19 test result for R1 was reported on 05/21/20 at 1:28 PM. R1's specimen was collected 05/17/20 at 6:00 PM. The test results documented R1 was negative for COVID-19. On 05/22/20 at 9:18 AM, Certified Nurse Aide (CNA) 5, who was working on D-wing, stated three residents currently resided on the wing. She stated two residents were new admissions and one resident, R1, had a fever and was moved to the wing. On 05/22/20 at 9:31 AM, the Administrator stated the three residents on D-wing were in quarantine and were all in private rooms. She stated none of the three residents had any signs/symptoms of COVID-19 and no residents had been on transmission-based precautions. She stated staff working in the isolation area were dedicated to that wing. On 05/22/20 at 12:08 PM, an interview was conducted with CNA5. She stated there had not been a contact/droplet isolation sign on the door of R1 all week. The CNA stated, throughout the week, no PPE container had been placed outside the resident's room and no containers for disposal of trash or linen had been placed inside the resident's room. She stated she wore PPE in the resident's room but did not remove it prior to exiting his room. She stated she walked to the double doors at the entrance to D-Wing to remove her PPE and placed them in a trash can with an opaque bag and a red Biohazard sign on the plastic trash can. She stated she had not been instructed to wear goggles or eye protection to enter R1's room. On 05/22/20 at 1:50 PM, Registered Nurse (RN) 7, charge nurse for D-wing, was asked the reason R1 had been moved to D-wing. She stated he had an isolated temperature of 101 degrees F the evening shift on 05/16/20 and was moved to D-wing. The RN stated she had worked on 05/17/20, 05/18/20, 05/20/20, and 05/21/20. When asked if the nurse practitioner had ordered R1 to be placed in contact and droplet isolation, she stated, That's what I understand. When asked if staff donned/doffed personal protective equipment (PPE) specifically for R1, she stated, Yes. When asked if the PPE had been removed and discarded inside the resident's room, she stated the trash container was near the end of the hall and staff walked there to remove and discard their PPE. When asked if red Biohazard trash bags had been used for the contact and droplet isolation for R1, the RN stated PPE was normally set up outside a resident's room if the resident was in isolation. She stated an isolation sign was normally placed on the door indicating the resident was in contact isolation and a red isolation bag was set up inside the room for trash and linen disposal. She stated, I have not seen any of that this week. On 05/22/20 at 2:40 PM, Housekeeper 6 was observed removing an opaque trash bag without a Biohazard sticker/sign from the plastic trash container labeled with a Biohazard sticker that was sitting inside the double doors of D-wing. The trash bag was not marked Biohazard. Housekeeper 6 stated he had worked on 05/18/20, 05/19/20, 05/20/20 and 05/22/20. Housekeeper 6 stated the trash bags used on the wing were not labeled as Biohazard and no isolation trash or linen containers had been set up inside the room of R1 during the week. He stated the trash removed from D-wing was disposed of in the same manner as the rest of the trash in the facility. On 05/22/20 at 2:59 PM, NP9, whom LPN1 documented had given a physician's order for contact/droplet isolation was interviewed by phone. NP9 stated, due to the resident's elevated temperature, she had given the order for R1 to be placed in contact/droplet isolation and intended for him to remain in isolation pending the results of the COVID-19 swab test. On 05/22/20 at 3:20 PM, in a telephone interview with the Director of Nursing (DON), the DON stated LPN10 had contacted her regarding R1's elevated temperature the evening of 05/16/20. When asked if she was aware NP9 had given an order for [REDACTED]. The DON stated she had instructed staff to place the resident in isolation. When informed staff had been interviewed and stated PPE had not been set up outside the room, no isolation sign had been placed on the resident's door, and no containers for removal of PPE inside the room had been set up, the DON stated, It sounds like they failed to do what I asked them to do. She stated she had not been back to D-wing all week. On 05/22/20 at 5:52 PM, RN13 was interviewed. RN13 stated she had worked on 05/18/20 and 05/21/20 and had been assigned to the residents on D-wing both days. RN13 stated there had never been a contact/droplet isolation sign on R1's door and no containers had been set up inside R1's room to discard trash or linens. RN13 stated there had been no trash bags marked Biohazard on D-wing. She stated she had received a verbal report at the change of shift on 05/18/20 that R1 was in quarantine, not in contact/droplet isolation. The facility's Isolation-Categories of Transmission-Based Precautions policy and procedure, dated 12/2015, provided by the administrator, documented: . Contact-Based Precautions. Place the individual in a private room if possible.In addition to wearing gloves as outlined in Standard Precautions, donning gloves (clean, non-sterile) prior to entering the resident's room.Remove gloves before leaving the room and perform hand hygiene.Wear a disposable gown upon entering the Contact Precautions room. Gown is to be donn (sic) prior to entering the resident's room and removed prior to exiting .Collect all trash, and place into a garbage bag. The bag is to have an indicator (Red Bag or Plastic bag w (with)/biohazard sticker) which indicates contents are Biohazard.Place all soiled linens including gowns, towels and privacy curtains into a sealed bag, (there are no recommendations for the use of Red bags or plastic bags w/ indicators for linen) dispose of once you leave the room to the soiled linen room. .Trash and linen receptacles are to be located in the resident room area with a foot controlled lid. .Droplet Precautions.In addition to Standard Precautions, put

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 -** Many	(continued... from page 1) a mask on when entering the room.Collect all trash, and place into a garbage bag. The bag is to have an indicator (Red Bag or Plastic bag w/ biohazard sticker) in which indicates contents are Biohazard. Biohazard trash bags are to be sealed and placed at the exit of the room till completion of resident care or cleaning has been done. Then all biohazard items are to be placed in the designated Biohazard storage area pending pick up by appropriate service. Place all soiled linens including gowns, towels and privacy curtains into a sealed bag. Trash and Linen receptacles are to be located in the resident room area with a foot controlled lid. The Centers for Disease Control and Prevention Preparing for COVID-19 in Nursing Homes guidance, updated 05/19/20, provided by the administrator, documented: .Residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room pending results of a [DIAGNOSES REDACTED]-CoV-2 (COVID-19) testing.While awaiting results of testing, HCP (healthcare provider) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e. goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents.