STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525504	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AUTUMN LAKE HEALTHCARE AT GREENFIELD	5790 S 27TH ST MILWAUKEE, WI 53221

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 properly prevent the spread of infections such as COVID-19 as evidenced by failures to: (1) ensure that a pulse oximeter (a medical device used to measure pulse and oxygen saturation level) shared among residents was properly cleaned and disinfected after resident use for one (R1) resident; (2) follow infection control practices related to the use of glucometers (medical device used to measure sugar levels in the blood) for three (R2, R3 and R4) residents; (3) perform hand hygiene when delivering clean laundry for 22 (R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24 and R25) residents; (4) ensure clean linens were handled to prevent contamination for two (R21 and R34) residents; (5) follow infection control practices related to the storage of clean linens in two halls (first floor east hall and second floor east hall); and, (6) perform hand hygiene when delivering meal trays for residents residing on the second floor and for eight (R26, R27, R28, R29, R30, R31, R32 and R33) residents residing in the Sub-Acute Unit. Staff failures to disinfect shared medical equipment, handle medical equipment to prevent contamination, perform hand hygiene while delivering clean laundry, ensure clean linens were handled to prevent contamination, follow infection control practices related to the storage of clean linens and perform hand hygiene when delivering meal trays had the potential to affect all residents who resided in the facility at the time of the survey. Findings include: 1. Review of the current [DIAGNOSES REDACTED]. Observation of Licensed Practical Nurse (LPN)1, on 4/29/20 at 10:25am, revealed LPN1 used the pulse oximeter to check R1's oxygen saturation level in R1's room. After using the pulse oximeter, LPN1 wiped the pulse oximeter with an alcohol wipe and put it back in the medication cart. In an interview with the DON on 4/29/20 at 2:21pm, when told about the observations of nursing staff not appropriately sanitizing the pulse oximeter after resident use, the DON stated, The pulse oximeter needs to be sanitized with the use of the Micro-Kill Bleach not alcohol wipes. Review of the facility's Pulse Oximetry (Assessing Oxygen Saturation) policy and procedure revised October 2010 revealed under Steps in the Procedure, .20. Disinfect probe using approved sanitizing agent . 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 . 2. Review of R2's, R3's and R4'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 the current [DIAGNOSES REDACTED]. Further review of R3's current [DIAGNOSES REDACTED]. According to the Centers for Disease Control and Prevention (CDC), People with moderate to severe asthma may be at higher risk of getting very sick from COVID-19. COVID-19 can affect your respiratory tract (nose, throat, lungs), cause an asthma attack, and possibly lead to pneumonia and acute respiratory disease. A. Observation of Medication Technician (MT)1, on 4/29/20 at 11:01am, revealed MT1 used the Assure Prism glucometer to check R2's blood sugar in R2's room. Without using any barrier to protect the glucometer from contamination by the surface of the medication cart, MT1 sat the glucometer on top of the medication cart. MT1 went to R2's room and sat the contaminated glucometer on R2's over-bed table. After checking R2's blood sugar, MT1 went back to the medication cart positioned outside R2's room and sat the contaminated glucometer on top of the medication cart without using any barrier. MT1 wiped the glucometer with the Micro-Kill Bleach wipe then kept the glucometer in a resealable bag then placed it in the top drawer of the medication cart. B. Observation of LPN2 on 4/29/20 at 12:04pm, revealed LPN2 used the Assure Prism glucometer to check R3's blood sugar in his room. Without using any barrier to protect the glucometer from contamination by the surface of the over-bed table, LPN2 sat the glucometer on R3's over-bed table. Before leaving R3's room, LPN2 sat the glucometer on top of R3's dresser. LPN2 went back to the medication cart positioned by the second floor dining room and put the contaminated glucometer in a small resealable bag and placed it in the top drawer of the medication cart without cleaning and disinfecting the glucometer. C. Observation of LPN1, on 4/29/20 at 12:07pm, revealed LPN1 used the Assure Prism glucometer to check R4's blood sugar in R4's room. Without using any barrier to protect the glucometer from contamination by the surface of the medication cart, LPN1 sat the glucometer on top of the medication cart. After checking R4's blood sugar, LPN1 wiped the glucometer with the Micro-Kill Bleach wipe, wrapped the glucometer with the same wipe and sat it on top of the medication cart. In an interview with the Director of Nursing (DON) on 4/29/20 at 2:21pm when told about the observation of nursing staff sitting the glucometer on residents' over-bed tables, dresser and medication cart without using any barrier, the DON stated, (Nursing staff should use a) barrier in between surfaces (and the glucometer). They should put it (glucometer) on a barrier or the surface should be cleaned and sanitized. When asked if the glucometer needed to be sanitized, the DON stated, It still needs to be sanitized even if assigned to just one resident. According to the Assure Prism Reference Manual, under Cleaning and Disinfecting the Meter, .The meter should be cleaned and disinfected after use on each patient .The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfection procedure. The disinfection procedure is needed to prevent the transmission of blood-borne pathogens .Two disposable wipes will be needed for each cleaning and disinfecting procedure; one wipe for cleaning and a second wipe for disinfecting . Review of the facility's Blood Sampling - Capillary (Finger Sticks) revised August 2012 revealed under, Steps in the Procedure, .3. Place blood glucose monitoring device on clean field .8. Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use . 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 . 3.A. Observation of a laundry staff (E1) on 4/29/20 at 11:40am 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, R16's, R17's, R18's, R19's, R20's, R21's, R22's, R23's, R24's and R25's rooms. Further observation revealed that E1 entered the 22 rooms to put clean laundry in the residents' closets and dressers. E1 went in and out of the 22 rooms without performing hand hygiene. In an interview with E1 on 4/29/20 at 11:58am when asked if she should have performed hand hygiene in between resident rooms while delivering clean laundry, E1 stated, I should (perform hand hygiene in between resident rooms) but I did not do it. When asked why she

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) should have performed hand hygiene in between resident rooms, E1 stated, I could transfer something from one room to the other. Review of R4's, R6's, R7's, R11's, R12's, R15's, R17's, R18's, R19's, R24's and R25's current [DIAGNOSES REDACTED]. Further review of R6's, R11's, R17's, R18's, R19's, R23's and R25's current [DIAGNOSES REDACTED]. In an interview with the DON on 4/29/20 at 2:21pm, when asked of her expectations of laundry staff when delivering clean laundry to residents' rooms, the DON stated, (Laundry staff should perform) hand hygiene in between (resident) rooms (when delivering laundry). Review of the facility's Hand Washing policy and procedure dated 2014 revealed that it did not address the necessity of performing hand hygiene when delivering clean laundry to residents' rooms. Further review of the same policy indicated under Compliance Guidelines: All facility personnel must wash their hands for 20 seconds under the following conditions: .3. After handling contaminated objects .8. Before handling clean .linens . The same policy also indicated under Additional Considerations: .If sinks are not readily available, a waterless antiseptic may be used between tasks normally requiring hand washing unless hands are visibly soiled . B.1) Observation on 4/29/20 at 11:53am revealed a nursing assistant (NA)1 was in the hallway handling linens and was holding them against her uniform. In an interview with NA1 on 4/29/20 at 11:57am, NA1 verified that she brought a bed sheet and a comforter in R21's room. NA1 further stated, They're clean. When asked if she should have held clean linens against her uniform, NA1 stated, (It was a) slight oversight. 2) Observation on 4/29/20 at 1:36pm revealed E1 was delivering clean laundry to R34's room and was holding them against her uniform. Review of R34's current [DIAGNOSES REDACTED]. In an interview with the DON on 4/29/20 at 2:21pm, when told about the observations of NA1 and E1 holding clean linens and laundry against their uniform, the DON stated, They (staff members) are not supposed to hold them against their uniform. (They should) hold (the linen or laundry) away from the body. Review of the facility's Departmental (Environmental Services) - Laundry and Linen policy and procedure revised April 2012 revealed under Steps in the Procedure - In Resident Rooms, 1. Do not allow linen, clean or soiled, to touch clothing or uniform . According to an article titled, Best Practice Guidelines - Handling and Storing Clean Linen in Healthcare Facilities, .It is possible for linen to become contaminated without appearing visibly soiled .it is essential that every effort is taken to avoid inadvertent contamination prior to use. Contaminated linen can serve as a vector for drug resistant organisms and other harmful pathogens .It is the responsibility of everyone who handles clean linen or is responsible for its storage within the facility to ensure compliance to these guidelines within their department .Linen should be carried slightly away from the body to avoid cross-contamination . C.1) Observation of the linen cart in the First Floor East Hall, on 4/29/20 at 10:10am, revealed that the linen cart was not covered and had incontinence briefs, a bottle of skin and hair cleanser and plastics bags on the top and bottom shelves. In an interview with NA7 on 4/29/20 at 10:14am, when asked if the above items should be put in the linen cart, NA7 stated, (I) don't know, I'm from the agency. 2) Observation of the linen cart in the Second Floor East Hall, on 4/29/20 at 11:36am, revealed that the linen cart was not covered and had incontinence briefs and box of gloves on the top shelf. Review of the resident room roster provided by the facility on 4/29/20 at approximately 4:08pm, revealed 18 residents resided on the First Floor East Hall and 25 residents on the Second Floor East Hall. In an interview with the Administrator on 4/29/20 at 2:48pm, when told about the above observations, the Administrator stated, Linen carts should be covered and only clean linens should be put in the cart. Review of the facility's Departmental (Environmental Services) - Laundry and Linen policy and procedure revised April 2012 revealed that it did not address the need for linen carts to be covered and what items were allowed to be stored in the linen carts. 4.A. Observation on 4/29/20 at 12:20pm revealed that NA1, NA2, NA3, NA4 and NA5 were distributing lunch trays to the residents on second floor. None of these staff members was observed performing hand hygiene before delivering the lunch trays in the dining room and to the resident rooms. These staff members assisted in setting up the residents' meals in the dining room and on the residents' over-bed tables in their rooms. Review of the resident room roster provided by the facility on 4/29/20 at approximately 4:08pm, revealed 43 residents resided on the Second Floor. B. Observation on 4/29/20 at 1pm revealed that NA6 brought lunch trays to R26's, R27's, R28's, R29's, R30's, R31's, R32's and R33's rooms. NA6 was not observed performing hand hygiene before delivering the lunch trays to the eight rooms. NA6 assisted in setting up the lunch trays on residents' over-bed tables then NA6 left their rooms without performing hand hygiene. Review of the current [DIAGNOSES REDACTED]. Further review of the current [DIAGNOSES REDACTED]. In an interview with the DON on 4/29/20 at 2:21pm, when told about the observations of lapses in hand hygiene by nursing staff while distributing meal trays to the residents on second floor and some residents in the Sub-Acute Unit, the DON stated, (They should do) hand hygiene in between trays. Review of the facility's Assisting the Resident with In-Room Meals policy and procedure, revised April 2011, revealed under Preparation, .10. Employees must wash their hands before serving food to residents. It is not necessary to wash hands between each resident tray; however, if there is contact with soiled dishes, clothing or the resident's personal effects, the employee must wash their hands before serving food to the next resident.