| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525241 | A. BUILDING _____ B. WING _____ | 06/16/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| EDGERTON CARE CENTER, INC | 313 STOUGHTON RD EDGERTON, WI 53534 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>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) appropriately disinfect face shield after use in rooms of residents under quarantine (a period or place of isolation in which people that have arrived from elsewhere or been exposed to infectious or contagious disease are placed) for three (R1, R2 and R3); (2) perform hand hygiene and follow infection control practices when delivering clean linen for 12 (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11 and R12) residents; (3) properly clean and disinfect a mechanical lift in between and/or after resident use for three (R5, R13 and R15) residents; and, (4) follow infection control practices related to the use of glucometer (medical device used to measure sugar levels in the blood) for four (R8, R14, R15 and R16) residents. Findings include: 1.A. Review of R1's Progress Notes dated 6/1/20 revealed, .Placed on droplet and contact isolation due to being in COVID-19 environment . Observation of a medication aide (MA1) on 6/9/20 at 1:45pm, revealed MA1 came out of R1's room and sprayed the Century Q 256 (Disinfectant Germicidal Detergent) on her face shield then immediately wiped it dry with a paper towel. B. Review of R2's Progress Notes dated 5/28/20 revealed, .Writer also updated that resident has a temporary room change D/T (due to) facility protocol for precautions after being in a COVID facility . 1) Observation of MA1 on 6/9/20 at 1:53pm, revealed MA1 came out of R2's room and sprayed the Century Q 256 on her face shield and immediately wiped it dry with a paper towel. 2) Observation of Nursing Aide (NA1) on 6/9/20 at 2:06pm, revealed NA1 came out of R2's room and sprayed the Century Q 256 on her face shield and immediately wiped it dry with a cloth wipe. 3) Observation of Registered Nurse (RN1) on 6/9/20 at 2:52pm, revealed RN1 came out of R2's room and sprayed her face shield with the Century Q 256 and immediately wiped it dry with a cloth wipe. C. Review of R3's Progress Notes dated 5/28/20 revealed, .Placed on contact and droplet precautions upon admit today due to being in COVID-19 environment . Observation of NA2 on 6/9/20 at 2:10pm, revealed NA2 came out of R3's room and sprayed her face shield with the Century Q 256 and immediately wiped it dry with a cloth wipe. In an interview with the Director of Nursing (DON) on 6/9/20 at 5:45pm, the DON stated, (Staff was given) training on cleaning their face shields when they come out of the rooms (on contact and droplet precautions) using (the Century Q) 256 and follow the contact time (also known as the wet time, is the time that the disinfectant needs to stay wet on a surface in order to ensure efficacy). Review of 256 Century Q Directions for Use revealed, .DISINFECTION/CLEANING .DIRECTIONS: .For Human Coronavirus, treated surfaces must remain wet for 1 minute. Wipe dry with a clean cloth .or allow to air dry . Review of the facility's COVID-19 Manual dated 5/11/20 revealed under Optimizing the Supply of Eye Protection, Face Shields during COVID-19 - Pandemic, .Remove (sic) eye protection will be removed, cleaned and disinfected if visibly soiled or if user is unable to see through .Adhere to recommended manufacturer instructions for cleaning and disinfection . 2. Review of R3's, R5's, R6's and R8's current [DIAGNOSES REDACTED]. Review of R3's, R5's, R8'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 the current [DIAGNOSES REDACTED]. Review of the current [DIAGNOSES REDACTED]. Sometimes the person can have both problems. The usual exchange between oxygen and carbon [MEDICATION NAME] in the lungs does not occur. As a result, enough oxygen cannot reach the heart, brain, or the rest of the body. This can cause symptoms such as shortness of breath, a bluish tint in the face and lips, and confusion. The most concerning complication of COVID-19 is acute hypoxaemic [MEDICAL CONDITION] requiring ventilation). Observation of NA3 on 6/9/20 at 2:17pm revealed that NA3 was delivering clean linens on second floor resident rooms. The clean linens were in a small cart that was not covered. A. Continuous observation of NA3 on 6/9/20 at 2:19pm revealed that NA3 was delivering clean linens for R1, R2, R3, R4 and R5. Observation also revealed that there were isolation bins set up outside these residents' rooms. Initially, NA3 put the clean linens on top of the isolation bins and later put them inside the isolation bins. In an interview with NA3 on 6/9/20 at 2:29pm, when asked if the linen cart should have been covered, NA3 stated, (I use the) cart uncovered normally. When asked where she should put the clean linens, NA3 stated, (I was) supposed to put linens inside the bins. Review of the facility's Handling Clean Linen policy and procedure dated 2017 revealed under Procedure, .3. The nursing staff places clean linen on the covered nursing cart to pass linen . Further review of the same policy and procedure revealed under Important Points, .Linen must be covered at all times until it is placed on the residents' bed, towel rack or used with cares . According to an article titled, Best Practice Guidelines - Storing and Handling Clean Linen in Healthcare Facilities, It is possible for linen to become contaminated without appearing visibly soiled. Therefore .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 . B. Continuous observation of NA3 revealed that NA3 delivered clean linens to R6's, R7's, R8's, R9's, R10's, R11's and R12's rooms. Further observation revealed that NA3 entered and exited these residents' rooms without performing hand hygiene. In an interview with NA3 on 6/9/20 at 2:29pm, when asked about the need to perform hand hygiene in between rooms when delivering clean linens to residents' rooms, NA3 stated, We normally do hand hygiene in between rooms but some rooms were out of hand sanitizer. In an interview with the DON on 6/9/20 at 5:52pm, when asked if the linen cart should have been covered, the DON stated, (Linen) cart should be covered. When told about the observation of NA3 putting the clean linens on top of the isolation bins and inside the isolation bins, the DON stated, (The linens were) not to be put on top of the isolation bin and on the drawer of the isolation bin. When asked of her expectations of nursing staff when delivering clean linens to residents' rooms, the DON stated, (Nursing staff should perform) hand hygiene in between (rooms). Review of the facility's Hand Hygiene policy and procedure dated 2017 revealed under Purpose: To cleanse hands to prevent the spread of potentially deadly infections; To provide a clean and healthy environment for residents, staff and visitors; To reduce the risk to the healthcare provider of colonization or infections acquired from a resident. Hand hygiene continues to be the primary means of preventing the transmission of infection . According to an article titled, Best Practice Guidelines - Storing and Handling Clean Linen in Healthcare Facilities, .Anyone handling clean linen should perform hand hygiene immediately prior to prevent contamination of linen . 3. Review of the current [DIAGNOSES REDACTED]. Further review of the current [DIAGNOSES REDACTED]. Observation on 6/9/20 at 4pm revealed that NA3 and NA4 used the sling mechanical lift to transfer R13 to a Broda chair (a wheelchair designed to offer tilt-in-space positioning which prevents skin breakdown through reducing heat and moisture for people in any type of healthcare setting). After using the mechanical lift with R13, NA3 and NA4 used the mechanical lift to transfer R5 from his bed to his wheelchair without sanitizing the mechanical lift. In an interview with NA4 on 6/9/20 at 5:23pm, when asked if the mechanical lift should have been disinfected after resident use, NA4 stated, Only after (use with a resident in an) isolation room. NA4 further stated, If (the resident was) not (on) isolation (precautions), (disinfection was) scheduled every shift. During the same interview, NA4 also mentioned that the mechanical lift was used with R15 to transfer R15 to bed to use the bedpan. When asked if the mechanical lift was disinfected after use, NA4 stated, We (NA3 and NA4) did not clean it after because she was not on |

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

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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>isolation (precautions). In an interview with the DON on 6/9/20 at 6:02pm, when told about the above observation of nursing assistants not sanitizing the mechanical lift after resident use, the DON stated, (The mechanical lift should be sanitized in) between residents with hydrogen peroxide wipes or (Century Q) 256 (disinfectant cleaner). Review of the facility's Environmental Services/Housekeeping/Laundry policy and procedure dated 2017 revealed under Cleaning of Medical Equipment, that it did not specifically address cleaning and disinfection of mechanical lifts. According to the website, https://www.myamericannurse.com article titled, Infection Control for Lifts and Slings published on September 11, 2007, .Mobile lifts should be cleaned regularly or according to the manufacturer's instructions. Normally, this means cleaning all external surfaces, using your institution's procedures for wiping down moveable medical equipment. A mobile lift should be cleaned before each patient uses it, particularly if the previous patient had a communicable disease or an infection, or if there's a risk of gross contamination. At a minimum, all surfaces that could have been touched by the previous patient - including the boom and mast, strap, sling bar, and hand control - should be wiped down with a chemical germicide registered by the EPA (Environmental Protection Agency) as a hospital disinfectant. Leave the solution in place for the prescribed time. Then, before the next patient uses the equipment, clean the disinfected surfaces a second time to remove traces of the disinfecting solution . 4. Review of R8's, R14's, R15's and R16's current [DIAGNOSES REDACTED]. Further review of R8's and R15's current [DIAGNOSES REDACTED]. [DIAGNOSES REDACTED]. Further review of R8's current [DIAGNOSES REDACTED]. Further review of R14's current [DIAGNOSES REDACTED]. A. Observation of RN1 on 6/9/20 at 4:02pm, revealed RN1 used the EvenCare G2 glucometer to check R14's blood sugar in R14's room. Without using any barrier to protect the blood glucose test strip case, glucometer case and glucometer from contamination by the surface of R14's over-bed table, RN1 sat the glucometer, glucometer case and blood glucose test strip case on R14's over-bed table. After checking R14's blood sugar, RN1 went back to the medication cart and sat the glucometer case and blood glucose test strip case on top of the medication cart without using a barrier. RN1 did not sanitize the glucometer and stated, Each resident has his/her own glucometer. B. Observation of Licensed Practical Nurse (LPN1), on 6/9/20 at 4:18pm, revealed LPN1 used the EvenCare G2 glucometer to check R15's blood sugar in R15's room. Without using any barrier to protect the glucometer and glucometer case from contamination by the surface of R15's over-bed table, LPN1 sat the glucometer and glucometer case on top of the over-bed table. After checking R15's blood sugar, LPN1 went back to the medication cart and sat the glucometer and glucometer case on top of the computer mouse pad on top of the medication cart without using a barrier. LPN1 wiped the glucometer with an alcohol wipe, kept it in the glucometer case and placed it on top of the medication cart without using any barrier. C. Observation of LPN1, on 6/9/20 at 4:22pm, revealed LPN1 used the EvenCare G2 glucometer to check R8's blood sugar in R8's room. Without using any barrier to protect the glucometer and glucometer case from contamination by the surface of R8's puzzle book on R8's over-bed table, LPN1 sat the glucometer and glucometer case on top of the puzzle book on R8's over-bed table. After checking R8's blood sugar, LPN1 went back to the medication cart and sat the glucometer case on top of the medication cart without using a barrier. LPN1 wiped the glucometer with an alcohol wipe and sat it on top of the medication cart. LPN1 kept the glucometer in the glucometer case and wiped the glucometer case with Clorox hydrogen peroxide wipe before keeping it in the medication cart. D. Observation of RN2 on 6/9/20 at 4:54pm, revealed RN2 used the EvenCare G2 glucometer to check R16's blood sugar in R16's room. Without using any barrier to protect the glucometer from contamination by the surface of R16's over-bed table, RN2 sat the glucometer on top of the over-bed table. After checking R16's blood sugar, RN2 went back to the medication cart and kept the glucometer in the glucometer case without disinfecting it. In an interview with the DON on 6/9/20 at 6:05pm, when told about the observation of nursing staff sitting the glucometer, glucometer case and blood glucose test strip case on residents' over-bed tables and medication cart without using any barrier, the DON stated, There should be a barrier (between surfaces and the glucometer, glucometer case and blood glucose test strip case). When asked if the glucometers should have been disinfected after resident use, the DON stated, (Nursing staff) should probably disinfect after each use especially with what's going on right now (pandemic) and without using a barrier. When asked if the alcohol wipe should have been used to disinfect the glucometer, the DON verified that alcohol wipes were only used for cleaning and not disinfecting glucometers. Review of the EvenCare G2 Blood Glucose Monitoring User's Guide revealed under Cleaning and Disinfecting your EvenCare G2 Meter, .3. To clean the meter, use a moist (not wet) lint-free cloth dampened with a mild detergent. Wipe all external areas of the meter or lancing device including both front and back surfaces until visibly clean .4. To disinfect your meter, clean the meter with one of the validated disinfecting wipes .Wipe all external areas of the meter or lancing device including both front and back surfaces until visibly clean .Allow the surface of the meter or lancing device to remain wet at room temperature for the contact time listed on the wipe's directions for use . Review of the facility's undated Glucose Monitoring policy and procedure revealed that the policy did not address the use of barrier or liner for the glucometer to protect it from contamination from environmental surfaces. 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 . |