STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525391	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WISCONSIN DELLS HEALTH SERVICES	300 RACE ST WISCONSIN DELLS, WI 53965

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 four (R1, R2, R3 and R4) residents; (2) observe social distancing when appropriate for 11 (R4, R5, R6, R7, R8, R9, R10, R11, R12, R13 and R14) residents; and, (3) perform hand hygiene when delivering clean laundry for eight (R1, R2, R15, R16, R17, R18, R19 and R20) residents in the sample of 20. Findings include: 1. Review of R1's, 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 R1's, R3's and R4's current [DIAGNOSES REDACTED]. Further review of R2's and R3's current [DIAGNOSES REDACTED]. Further review of the current [DIAGNOSES REDACTED]. A.1) Observation of Licensed Practical Nurse (LPN1) on 6/23/20 at 11:25am, revealed LPN1 used the Gluco Navii glucometer to check R1's blood sugar in his 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 R1's blood sugar, LPN1 went back to the medication cart, put the glucometer in the glucometer case then put it in the medication cart without disinfecting the glucometer. Continuous observation of LPN1 revealed LPN1 administered R1's insulin in his room. Without using a barrier to protect the insulin pen and gloves from contamination by the surface of R1's over-bed table, LPN1 sat the insulin pen and gloves on R1's over-bed table before administering R1's insulin. After administering R1's insulin, LPN1 went back to the medication cart and sat the contaminated insulin pen on top of the medication cart before keeping it inside the medication cart. 2) Observation of LPN1 on 6/23/20 at 11:42am, revealed LPN1 used the Gluco Navii glucometer to check R2's blood sugar in his 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 R2's blood sugar, LPN1 kept the glucometer in the glucometer case then kept it in the medication cart without disinfecting the glucometer. Continuous observation of LPN1 revealed LPN1 administered R2's insulin in his room. Without using a barrier to protect the insulin pen from contamination by the surface of the medication cart and R2's over-bed table, LPN1 sat the insulin pen on the medication cart and R2's over-bed table before and after administering R2's insulin. In an interview with the Infection Preventionist on 6/23/20 at 3:26pm, when told about the above observations, the Infection Preventionist stated, (There should be a) barrier on the med (medication) cart and over-bed table. When asked of her expectations of nurses after glucometer use, the Infection Preventionist stated, (I) expect (the glucometer) to be cleaned and disinfected. B.1) Observation of Registered Nurse (RN1), on 6/23/20 at 11:57am, revealed RN1 used the Gluco Navii glucometer to check R3's blood sugar in R3's room. Without using any barrier to protect the glucometer and gloves from contamination by the surface of the medication cart, RN1 sat the glucometer and gloves on top of the medication cart. Before entering R3's room, RN1 put the glucometer and supplies (lancet, glucose test strip, alcohol wipe and gloves) inside his pocket. After checking R3's blood sugar, RN1 wiped the glucometer after use with the Sani-Hands wipe (a hand hygiene solution for staff, visitors, patients or residents who cannot get out of bed to clean their hands) for two seconds, RN1 then put the glucometer in its case and in the medication cart without proper disinfection. 2) Observation of RN1, on 6/23/20 at 12:05pm, revealed RN1 used the Gluco Navii glucometer to check R4's blood sugar in R4's room. Without using any barrier to protect the glucometer case from contamination by the surface of R4's dresser, RN1 sat the glucometer case on top of R4's dresser. After checking R4's blood sugar, RN1 put the contaminated glucometer case on top of the medication cart then wiped the glucometer with Sani-Hands for three seconds. RN1 kept the glucometer in its case then kept it in the medication cart without proper disinfection. In an interview with the Infection Preventionist on 6/23/20 at 3:34pm, when told about the above observations, the Infection Preventionist stated, (I do) not expect (the nurse) to put (the glucometer and supplies) in his pocket. (There will be cross) contamination in the pocket. When asked what the nurse should use to disinfect the glucometer after resident use, the Infection Preventionist stated, Disinfectant wipes (should be used to disinfect the glucometer after use). Sani-Hands (wipe was) not for glucometer. Review of the facility's Obtaining a Fingerstick Glucose Level policy and procedure dated 12/2016 revealed that it did not address the use of barrier or liner for the glucometer to protect it from contamination from environmental surfaces. Further, the policy and procedure did not address that medical equipment like glucometer should not be carried in pockets. Further review of the same policy and procedure revealed under Steps in the Procedure, .18. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice . Review of the Gluco Navii Operations and Procedures Manual revealed under Important Safety Precautions, .Users need to adhere to Standard Precautions when handling or using this device. All parts of the glucose monitoring system should be considered potentially infectious and are capable of transmitting blood-borne pathogens between patients and healthcare professionals .The Gluco Navii meter should be disinfected after use on each patient . 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. Review of R4's and R11's current [DIAGNOSES REDACTED]. Further review of R4's and R13's current [DIAGNOSES REDACTED]. Review of the current [DIAGNOSES REDACTED]. Further review of R5's and R14's current [DIAGNOSES REDACTED]. Review of R6's, R8's, R9's, R12's and R14's current [DIAGNOSES REDACTED]. Review of R7's, R10's and R11's current [DIAGNOSES REDACTED]. A. Observation on 6/23/20 at 12:05pm revealed that R4 and R5 were sitting right next to each other in their room and both residents were not wearing mask. B. Observation on 6/26/20 at 12:13pm revealed that R6, R7 and R8 were eating lunch at a square table. The three residents were approximately three feet away from each other while a nursing assistant (NA1) was supervising them during the meal. Continuous observation revealed that R9 and R10 were eating lunch at a round table. The two residents were approximately four feet away from each oher. In an interview with NA2 on 6/23/20 at 12:51pm, when asked about the above observations, NA2 stated, They are not far enough (from each other). When asked how far the residents were from each other, NA2 stated, Three to four feet away. In an interview with the Infection Preventionist on 6/23/20 at 3:40pm, when told about the observations in the 300 Hall dining room, she stated, We try as best as we can. C. Observation on 6/23/20 at 10:30am and 12:58pm revealed that R11 and R12 were sitting right next to each other in their room and both residents were not wearing mask. D. Observation on 6/23/20 at 10:30am and 12:59pm revealed that R13 and R14 were sitting right next to each other in their room and both residents were not wearing mask. In an interview with the Infection Preventionist on 6/23/20 at 3:46pm, when told about the observations of R4, R5, R11, R12, R13 and R14 sitting right next to each other in their respective rooms and when asked how social distancing could have been maintained, she stated, Pulling the curtains close (could have maintained social distancing between residents). The Infection Preventionist further stated, (Pulling the curtains close was being done for residents on) 14-day quarantine (a

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) state, period, or place of isolation in which people or animals that have arrived from elsewhere or been exposed to infectious or contagious disease are placed) but (we) have not thought about it with long term care residents. Review of the facility's Suspected or Confirmed Positive COVID 19 Management policy and procedure last revised on 6/18/20 revealed under Procedure, .2) .The center will enforce social distancing (six feet away from others) between residents and staff . Further review of the same policy and procedure revealed under Procedure, .d. The center will minimize resident contact in the center .3) .Residents requiring assist with meals or those with safety risks associated with eating will be assisted by staff in the dining room. Residents will maintain social distancing in the dining room . According to the Centers for Disease Control and Prevention's publication on Social Distancing .keeping space between you and others is one of the best tools we have to avoid being exposed to this virus (COVID-19) and slowing its spread .Since people can spread [MEDICAL CONDITION] before they know they are sick, it is important to stay away from others when possible, even if you - or they - have no symptoms. Social distancing is especially important for people who are at higher risk for severe illness from COVID-19 .COVID-19 spread mainly among people who are in close contact (within about 6 feet) for a prolonged period .It may be possible that a person can get COVID-19 by touching a surface or object that has [MEDICAL CONDITION] on it and then touching their own mouth, nose, or eyes .Social distancing helps limit opportunities to come in contact with contaminated surfaces and infected people . 3. Observation of the Laundry Manager (E1) on 6/23/20 at 2:53pm revealed that E1 was delivering clean laundry to R1's, R2's, R15's, R16's, R17's, R18's, R19's and R20's rooms. Further observation revealed that E1 entered and exited the residents' rooms without performing hand hygiene. Review of R1's, R2's, R15's, R16's, R18's, R19's and R20's current [DIAGNOSES REDACTED]. Further review of R1's and R19's current [DIAGNOSES REDACTED]. Further review of R2's, R15's and R16's current [DIAGNOSES REDACTED]. Review of R17's current [DIAGNOSES REDACTED]. Further review of the current [DIAGNOSES REDACTED]. Further review of the current [DIAGNOSES REDACTED]. In an interview with the Infection Preventionist on 6/23/20 at 3:52pm, when asked of her expectations of staff when delivering clean laundry to residents' rooms, she stated, (Staff should perform) hand hygiene before and after (delivering clean laundry in residents' rooms). Review of the facility's Handling Clean Linen policy and procedure dated 2017 revealed that it did not address the necessity of performing hand hygiene when delivering clean laundry in between resident rooms. According to an article titled, Best Practice Guidelines - Storing and Handling Clean Linen in Healthcare Facilities revealed under Storage and Handling Procedures - Clinical/Patient Environment, 1. Anyone handling clean linen should perform hand hygiene immediately prior to prevent contamination of linen .