STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525653	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VIRGINIA HIGHLANDS HLTH AND REHAB	W173 N10915 BERNIES WAY GERMANTOWN, WI 53022

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 three (R1, R2 and R3) residents; (2) perform hand hygiene when delivering meal trays for residents residing in the 500 Hall; (3) ensure clean linens were handled to prevent contamination for two (R4 and R5) residents; and, (4) clean and disinfect a mechanical lift after resident use for one (R6) resident. Findings include: 1. Review of R1's, R2's and R3'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 current [DIAGNOSES REDACTED]. Further review of R2's current [DIAGNOSES REDACTED]. Further review of R3's current [DIAGNOSES REDACTED].People of any age with the following conditions are at increased risk of severe illness from COVID-19: [MEDICAL CONDITIONS] .obesity (body mass index (BMI) of 30 or higher, serious heart conditions, such as heart failure, [MEDICAL CONDITION] .type 2 diabetes mellitus .people with the following conditions might be at an increased risk for severe illness from COVID-19: .hypertension or high blood pressure . A. Observation of Licensed Practical Nurse (LPN1) on 6/30/20 at 11:23am, revealed LPN1 used the glucometer to check R1's blood sugar in R1'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 R1's blood sugar, LPN1 went back to the medication cart, wiped the glucometer with a Clorox wipe for five seconds and sat the glucometer on top of the medication cart without using any barrier. The glucometer was visibly wet for 15 seconds. B. Observation of LPN1, on 6/30/20 at 11:31am, revealed LPN1 used the 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 and R2's over-bed table, LPN1 sat the glucometer on top of the medication cart and R2's over-bed table. C. Observation of LPN1, on 6/30/20 at 11:43am, revealed LPN1 used the glucometer to check R3's blood sugar in R3'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. LPN1 went to R3's room and sat the contaminated glucometer on R3's over-bed table. After checking R3's blood sugar, LPN1 went back to the medication cart and sat the contaminated glucometer case on top of the medication cart without using any barrier. LPN1 wiped the glucometer with the Clorox wipe for five seconds, wrapped the glucometer with the same wipe and put it in a plastic cup. The glucometer was visibly wet for two minutes. In an interview with the Infection Preventionist on 6/30/20 at 2:05pm when told about the observation of nursing staff sitting the glucometer on residents' over-bed tables and medication cart without using any barrier, the Infection Preventionist stated, (The nursing staff should use a) barrier (and) not put (the glucometer) directly on the table. When asked about the contact time (also known as the wet time and the time that the disinfectant needs to stay wet on a surface in order to ensure efficacy) of the Clorox wipe, the Infection Preventionist stated, (The nursing staff) should follow (the contact time). According to the Clorox Disinfecting Wipes Competitive Comparison of Dwell Times, How long surface must remain wet to achieve disinfection of bacteria .4 minutes . Review of the facility's Glucometer Decontamination) policy and procedure dated 9/2015 revealed under Policy: The glucometer shall be decontaminated with the facility approved wipes following use on each resident. Gloves will be worn and the manufacturer's recommendations will be followed. Further review of the same policy and procedure revealed under Procedure: I. The nurse will obtain the glucometer along with the wipes and place the glucometer on the overbed (sic) table on a clean surface, e.g., paper towel, wax paper. II. Cleaning and disinfecting the glucometer: A. After performing the glucometer testing, the nurse shall .use the disinfectant wipe to clean all external parts of the glucometer. A specific amount of wet time is not required for cleaning .C. A second wipe shall be used to disinfect the glucometer, allowing the meter to remain wet for the contact time required by the disinfectant label; D. The clean glucometer will be placed on another paper towel . 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 on 6/30/20 at 12:15pm revealed that the Nursing Assistant (NA1), NA2 and NA3 were distributing lunch trays to the residents in the 500 Hall. None of these staff members was observed doing hand hygiene before delivering the lunch trays in the dining room and to the resident rooms. Review of the resident room roster provided by the facility on 6/30/20 at 10:34am, revealed 26 residents resided in the 500 Hall. In an interview with the Infection Preventionist on 6/30/20 at 2:14pm, when told about the observations of lapses in hand hygiene by nursing staff while distributing meal trays to the residents in the 500 Hall, the Infection Preventionist stated, (They should perform) hand hygiene in between residents and rooms. Review of the facility's Tool Kit A - Section I Center Preparedness: Infection Prevention Strategies and Guidance for COVID-19 policy and procedure, updated on June 10, 2020, revealed on page 22 under Communal Dining, .Staff should exercise proper hand hygiene and will assist residents/patients with proper hand hygiene . Review of the facility's Hand Hygiene policy and procedure, revised on 2/2018, revealed under Policy: .Using an alcohol-based hand rub is appropriate for decontaminating the hands before direct patient contact .after contact with a patient .and after contact with inanimate objects in the patient's environment . 3. Review of R4's current [DIAGNOSES REDACTED]. A. Observation on 6/30/20 at 10:04am revealed a Medication Technician (MT1) was in the hallway handling a clean hospital gown and was holding it against her plastic disposable gown as she was applying sanitizer on her hands. MT1 went to R4's room. In an interview with MT1 on 6/30/20 at 12:15pm, when told about the above observation, MT1 stated, (It was) not my intention. When asked what could happen as a result of what she did, MT1 stated, I could transmit an infection to him. B. Observation on 6/30/20 at 10:50am revealed NA1 was in the hallway handling clean linens and was holding them against her plastic disposable gown. NA1 went to R5's room and placed the contaminated linens on the empty resident's bed (R5 did not have a roommate). In an interview with the Infection Preventionist on 6/30/20 at 1:59pm, when told about the above observations of MT1 and NA1 holding clean linens against their plastic disposable gown, the Infection Preventionist stated, Linen should not touch your clothing or gowns (because they are) considered dirty on the outside. The facility's Handling Clean Linen policy and procedure was requested but the facility was unable to provide. 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 . 4. Observation on 6/30/20 at 10:05am revealed that NA1 was coming out of R6's room with a mechanical lift which NA1 initially parked outside of R6's room. NA1 took the mechanical lift back and left it inside R6's room and left the room without

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) disinfecting the mechanical lift. Review of R6's current [DIAGNOSES REDACTED]. In an interview with the Infection Preventionist on 6/30/20 at 2:01pm, when told about the above observation of NA1 not disinfecting the mechanical lift after use, the Infection Preventionist stated, (The mechanical lift) should be sanitized after use with residents. Review of the facility's undated Competency: Use of Mechanical Lift(s) revealed that it did not address disinfection of the mechanical lift after resident use. 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 .