

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 525418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2020
NAME OF PROVIDER OF SUPPLIER EVANSVILLE MANOR NURSING AND REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP 470 GARFIELD AVE EVANSVILLE, WI 53536	
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 Level of harm - Minimal harm or potential for actual harm Residents Affected - Many	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>This deficiency has two deficient practice statements: 1. Based on observation, interview and record review the facility failed to properly prevent the spread of infections such as COVID-19 and failed to implement infection control practices according to the Centers for Disease Control and Prevention (CDC) guidelines on newly admitted or returning residents, as evidenced by failures to: (A) prevent cohorting (imposed grouping of people, such as patients, potentially exposed to designated diseases) four (R1, R2, R11 and R12) residents with two of these residents under monitoring due to possible exposure to COVID-19 during hospitalization while the other two residents were asymptomatic and confirmed negative from COVID-19; and, (B) place newly admitted or readmitted residents on appropriate transmission based precautions after being discharged from the hospital and ensure nursing staff donned appropriate personal protective equipment (PPE) per CDC's recommendation when entering the rooms of 11 (R1, R3, R4, R5, R6, R7, R8, R9, R10, R11 and R13) residents which should be under monitoring due to possible exposure to COVID-19 during hospitalization. These practices had the potential to affect all residents who resided in the facility at the time of the survey. Findings include: According to the Centers for Disease Control and Prevention, Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE (which includes use of 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). Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home. New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). Testing at the end of this period could be considered to increase certainty. According to the website https://www.itnonline.com from an article titled COVID-19 Genetic PCR Tests Give False Negative Results if Used Too Early published on 6/10/20, In a new study, Johns Hopkins researchers found that testing people for [DIAGNOSES REDACTED]-CoV-2 (COVID-19) too early in the course of infection is likely to result in a false negative test, even though they may eventually test positive for [MEDICAL CONDITION]. This is important to understand since many hospitals are using these COVID tests to screen patients before imaging exams, diagnostic testing or procedures. The report found even a week after infection, one in five people who had [MEDICAL CONDITION] had a negative test result. The findings was published in the May 13 issue of Annals of Internal Medicine. The article further stated, A negative test, whether or not a person has symptoms, doesn't guarantee that they aren't infected by [MEDICAL CONDITION], said Lauren Kucirka, M.D., Ph.D., M.Sc., obstetrics and gynecology resident at Johns Hopkins Medicine. How we respond to, and interpret, a negative test is very important because we place others at risk when we assume the test is perfect. However, those infected with [MEDICAL CONDITION] are still able to potentially spread [MEDICAL CONDITION]. The same article further indicated, Kucirka said patients who have a high-risk exposure should be treated as if they are infected, particularly if they have symptoms consistent with COVID-19. This means communicating with patients about the tests' shortcomings. One of several ways to assess for the presence of [DIAGNOSES REDACTED]-CoV-2 infection is a method called reverse transcriptase polymerase chain reaction (RT-PCR). These tests rapidly make copies of and detect [MEDICAL CONDITION]'s genetic material. However, as shown in tests for other viruses such as influenza, if a swab misses collecting cells infected with [MEDICAL CONDITION], or if virus levels are very low early during the infection, some RT-PCR tests can produce negative results. Since the tests return relatively rapid results, they have been widely used among high-risk populations such as nursing home residents, hospitalized patients and healthcare workers. Previous studies have shown or suggested false negatives in these populations. The researchers estimated that those tested with [DIAGNOSES REDACTED]-CoV-2 in the four days after infection were 67 percent more likely to test negative, even if they had [MEDICAL CONDITION]. When the average patient began displaying symptoms of [MEDICAL CONDITION], the false-negative rate was 38 percent. The test performed best eight days after infection (on average, three days after symptom onset), but even then had a false negative rate of 20 percent, meaning one in five people who had [MEDICAL CONDITION] had a negative test result. The article also stated, We are using these tests to rule out COVID-19, and basing decisions about what steps we take to prevent onward transmission, such as selection of personal protective equipment for healthcare workers, Kucirka explained. As we develop strategies to reopen services, businesses and other venues that rely on testing and contact tracing, it is important to understand the limitations of these tests. The sooner people can be accurately tested and isolated from others, the better we can control the spread of [MEDICAL CONDITION], the researchers said. In an interview with the Administrator in the presence of the Director of Nursing (DON) and the Nurse Consultant, on 6/10/20 at 11am, the Administrator stated, Newly admitted or readmitted residents who have two negative COVID-19 test results in the hospital are put on standard precautions (the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed status of the patient and based on a risk assessment and make use of common sense practices and personal protective equipment use that protect healthcare providers from infection and prevent the spread of infection from patient to patient) upon admission (to the facility). Residents who have one negative COVID-19 test result are put on droplet precautions (transmission-based precautions that are used in addition to Standard Precautions for patients with known or suspected infections that can be spread to others by speaking, sneezing, or coughing and require use of mask, gown and gloves) and quarantined (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 14 days. A. Review of the facility's Admission and Transfer of Residents from Hospital during COVID19 Pandemic policy and procedure last revised on 5/26/20 revealed under Purpose, To reduce the risk of transmission of the Coronavirus Disease (COVID-2019) to residents and staff in skilled nursing facility from residents admitting or transferring from the hospital. Due to the constantly changing and fluid nature of [MEDICAL CONDITION]; the facilities will monitor, follow, and implement recommendations and guidelines in accordance with the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), CMS, and the State Department of Health to include identification and isolation of any suspected cases. 1) Observation on 6/10/20 during the duration of the survey, revealed that R1 and R2 shared the same room. Further observation revealed that there was no isolation set-up outside of R1's and R2's room and there was no sign indicating that these residents were on contact and droplet isolation precautions. Review of R1's Census Record revealed that R1 was readmitted to the facility on [DATE]. R1 was cohorted with R2 and the two residents became roommates on 6/4/20 and continued as such until 6/10/20. Review of R2's Census Record revealed that R2 was readmitted to the facility on [DATE] and returned to her previous room which R2 shared with R1 from 6/4/20 until 6/10/20. Review of R2's Progress Notes from 5/22/20 until 6/5/20 revealed no indication that R2's contact and droplet precautions (if they were appropriately put in place by the facility) should have been extended after 6/5/20 when R1 was cohorted with R2 in one room and caused unnecessary possible re-exposure of R2 to COVID-19. Review of R1's current, completed and discontinued physician orders [REDACTED]. Review of R1's current care plans, including resolved and cancelled items on the care plan, revealed that there was no indication that R1 was put on contact and droplet isolation precautions when she was readmitted to the facility on [DATE].</p>		

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	<p>(continued... from page 1)</p> <p>Per CDC guidelines, R1 should have been on contact and droplet precautions from 6/5/20 until 6/18/20. Observation on 6/10/20 during the duration of the survey revealed that R1 was not on any isolation precautions. Review of the undated (List of Residents on) Isolation (Precautions) provided by the Director of Nursing (DON) revealed that R1 was not on the list of residents that were on transmission based precautions. Review of R2's 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.</p> <p>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 (with abnormally low amount of oxygen in the blood, especially arterial blood) [MEDICAL CONDITION] requiring ventilation). R2 also had [DIAGNOSES REDACTED].) tube rather than through the nose and mouth). Further review of the current [DIAGNOSES REDACTED]. Review of the facility's Isolation Precautions policy and procedure last revised on 3/20/20 revealed under Contact Precautions: 1. Implemented for residents suspected or confirmed to be infected with a communicable disease/infection that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces/equipment in the resident's environment; 2. Residents shall be placed in a private room when available. If private room is not available, residents may be cohorted with a low risk roommate upon evaluation of risks associated with cohorting . Further review of the same policy and procedure revealed under Droplet Precautions, 1. Implement droplet precautions for resident with suspected or confirmed to be infected with a communicable disease/infection transmitted via droplets generated by sneezing, talking, or during procedures such as suctioning; 2. Residents shall be placed in a private room when available. If a private room is not available, residents may be cohorted with a low risk roommate upon evaluation of risks associated with cohorting . 2) Observation on 6/10/20 during the duration of the survey, revealed that R11 and R12 shared the same room. Further observation revealed that there was no isolation set-up outside of R11's and R12's room and there was no sign indicating that these residents were on contact and droplet isolation precautions. Review of the Resident Listing Report dated 6/10/20 revealed that R11 and R2 shared the same room. Review of R11's Census Record revealed that R11 was readmitted to the facility on [DATE]. R11 was cohorted with R12 and the two residents became roommates on 6/8/20 and continued as such until 6/10/20. Review of R11's current, completed and discontinued physician orders [REDACTED]. Review of R12's Census Record revealed that R12 was admitted to the facility on [DATE] and would have been off quarantine and off contact and droplet precautions on 5/5/20. Review of R12's Progress Notes from 4/20/20 until 5/5/20 revealed no indication that R12's contact and droplet precautions (if appropriately put in place by the facility) should have been extended after 5/5/20 until R11 was cohorted with R12 in one room and caused unnecessary possible re-exposure of R12 to COVID-19. Review of R12's current physician orders [REDACTED]. Review of R12's physician order [REDACTED]. B. According to the Centers for Disease Control and Prevention, .All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of 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 .Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic [DIAGNOSES REDACTED]-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home .New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). Testing at the end of this period could be considered to increase certainty . According to the website https://www.biotechniques.com from an article titled False negatives: how accurate are PCR (polymerase chain reaction) tests for COVID-19? published on 5/29/20, . As the COVID-19 pandemic spread and the importance of testing was proven, attention was on PCR as institutions all over the world developed new diagnostic tests for detecting [DIAGNOSES REDACTED]-CoV-2. Researchers and clinicians around the globe have been using the RT-PCR (real-time reverse transcription polymerase chain reaction) technique to find out whether a person has been infected. These tests have played a vital role in many countries' response to the disease by allowing epidemiologists to better track the spread and determine infection rates in given areas .However, new research from Johns Hopkins University (MD, USA) has found that the chance of these tests giving a false negative - stating no infection when the individual actually is infected - is greater than 1 in 5, at times being far higher. The study, which analyzed seven previously published studies that evaluated RT-PCR performance, calls into question the accuracy of the predictive value of such tests .The relatively high rate of false negative results, combined with the 'silent spread' from asymptomatic individuals, has likely led to the high number of patients contracting [MEDICAL CONDITION] in a hospital setting .In order to reduce the impact of false negative COVID-19 results, clinicians should be aware of the pitfalls in the test's accuracy and share with patients that a negative result does not necessarily mean no infection; if experiencing symptoms an individual should self-isolate, regardless of test result . 1) Review of the Admission Report dated 6/10/20 revealed that R1, R3, R4, R5, R6, R7, R8, R9, R10, R11 and R13 were newly admitted /readmitted to the facility from 5/27/20 to 6/10/20. Review of the undated (List of Residents on) Isolation (Precautions) provided by the DON revealed that R1, R4, R5, R6, R7, R8, R9, R10, R11 and R13 were not on the list of residents that were on transmission based precautions. The same list indicated that R3 was on contact precautions due to [MEDICAL CONDITION] infection but not on transmission-based precautions due to possible exposure to COVID-19 during hospitalization . Observation on 6/10/20 during the duration of the survey revealed that there were no isolation set-ups outside of R1's, R4's, R5's, R6's, R7's, R8's, R9's, R10's, R11's and R13's rooms and there were no signs indicating that these residents were on contact and droplet isolation precautions. Further observation revealed that staff members went in and out of these residents' rooms only wearing surgical mask and goggles/face shield. Review of the facility's Isolation Precautions policy and procedure last revised on 3/20/20 revealed under Purpose: To establish transmission-based precautions for resident (sic) who are suspected or confirmed to have communicable diseases/infections that can be transmitted to other (sic). Further review of the same policy and procedure revealed under Procedure, 1. Transmission-based precautions will be used when transmission cannot be reasonably prevented by standard precautions alone; 2. Appropriate communication/notices will identify the resident/room with isolation precautions implemented. 2) Observation on 6/10/20 at 12:50pm, revealed that the Speech Language Pathologist (SLP)1 went inside R1's and R2's (roommates) room to assess and evaluate R1's swallowing technique during lunch. SLP1 was only wearing a surgical mask and face shield. SLP1 was not wearing any gloves nor was SLP1 wearing a gown. In an interview with SLP1 on 6/10/20 at 2:23pm, when asked what she would have done differently if the resident (R1) she was assessing and evaluating for swallowing was under monitoring for possible COVID-19 exposure during hospitalization , SLP1 stated, I would have full PPE on, gown, gloves, mask, eye shield. Sanitize before and after, six feet away (from the resident). (I would have been) more cautious as to trying to make her cough (as it is) hard to tell if the cough is related to swallowing problem or symptoms of COVID. SLP1 further stated, Rather than to advance the diet, (I would) work more on strengthening exercise rather than advancing the diet (that way, R1 is) still working on improving swallowing but not going to get a false idea of the safety of her swallow. SLP1 also stated, (People infected with COVID-19 are) prone to have pneumonia. You don't want to make that worse so you don't want to advance the diet (as) they are prone to get pneumonia with COVID. When asked if (R1) coughed during her swallowing evaluation, SLP1 stated, (R1) coughed one time during the whole meal when she took a sip of nectar (thick) liquid. When asked how far she was from the resident at that time, SLP1 stated, Three feet away from the resident. During the same interview, SLP1 further stated, (R9) had a swallow study that says she's safe but has been gagging sometimes. When asked if she would have worked differently with R9 if she knew R9 was under monitoring for COVID-19 due to possible exposure to COVID-19 during hospitalization , SLP1 stated, (I would) have done the same precautions she would have done with (R1). Gagging could probably spread it too and they are not wearing a mask. That's why we need the (full) PPE especially with the nature of my job. 3) Observation on 6/10/20 at 1pm, revealed that the Occupational Therapist (OT1) took R8 to the therapy room for some exercises. OT1 was only wearing a surgical mask and goggles but was not wearing gown and gloves. In an interview with OT1 on 6/10/20 at 2:14pm, when asked what she would have done differently if the resident (R8) she was doing occupational therapy with was under monitoring for possible COVID-19 exposure during hospitalization , OT1 stated, (I would) not take them out of the room, (wear) different PPE, N95 (mask), gown and gloves, (stay away) six to 10 feet apart. When asked how was staff made aware if any resident was under monitoring for possible exposure to COVID-19, OT1 stated, Nursing will let us know or our boss will let us know, (isolation) set-up (outside the resident room), precautions sign. 4) Review of the Resident Listing Report by Location dated 6/10/20 revealed that R1, R5 and R7 were resided in the 400 hall; R3, R6, R8, R9</p>		

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F 0880 Level of harm - Minimal harm or potential for actual harm Residents Affected - Many	<p>(continued... from page 2)</p> <p>and 10 were resided in the 100 hall; and, R4, R11 and R13 were resided in the 200 hall. In an interview with the DON on 6/10/20 at 2:55pm, the DON stated, One nurse is assigned to 100 hall, one nurse for the 200 hall and one nurse for the 200 and 400 halls. The DON also stated, The 100 and 300 hall nurses also help the 200/400 nurse. When asked about the nursing assistant (NA) assignments, the DON stated, During morning and evening shifts, there is one NA per hallway and two floats (NA that could help the different hallways), one for 100 and 200 halls and the other helps with 300 and 400 halls. The DON further stated, There is one shower aide every day shift who helps with showers, help pass trays, help with transfers and taking weights. During the same interview, the DON indicated, There are two nurses for the night shift, one for the 100 and 200 halls and one nurse for the 300 and 400 halls. The DON also stated, There are three nursing assistants during night shift. 200, 300 and 400 are assigned then they split up the 100 hall but they all work together and help each other. Interview with the DON revealed that the staff members working with the residents who were supposed to be on transmission-based precautions had the potential to work with any other residents in the facility. Therefore, the failure to place newly admitted or readmitted residents on appropriate transmission based precautions after being discharged from the hospital and ensure nursing staff donned appropriate PPE per CDC's recommendation when entering the rooms of the 11 (R1, R3, R4, R5, R6, R7, R8, R9, R10, R11 and R13) residents which should be under monitoring due to possible exposure to COVID-19 during hospitalization, had the potential to affect all residents who resided in the facility at the time of the survey. Review of the facility's Isolation Precautions last revised on 3/20/20, revealed under Contact Precautions, .3. Prior to entering the isolation room, the following steps are required: a. Perform hand-hygiene and apply gloves and gown prior to entering room. Further review of the same policy revealed under Droplet Precautions, .3. Prior to entering the isolation room, the following steps are required: a. Perform hand-hygiene and apply gloves and mask prior to entering room. 2. 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: (A) follow infection control practices related to the use of glucometer (medical device used to measure sugar levels in the blood) for two (R14 and R15) residents; and, (B) ensure that pulse oximeter (medical device used to measure pulse rate and oxygen saturation level) and blood pressure (BP) cuff shared among residents were properly cleaned and disinfected after resident use for eight (R16, R17, R18, R19, R20, R21, R22 and R23) residents. Findings include: A. Review of R14's and R15'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 R14'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. 1) Observation of Licensed Practical Nurse (LPN1) on 6/10/20 at 11:39am, revealed LPN1 used the Ultra Trak Complete glucometer to check R14's blood sugar in R14's room. Before going inside R14's room, LPN1 stated, She's neutropenic (has a condition that results when the body does not have enough [DIAGNOSES REDACTED]s, an important white blood cell that fights infections. The lower your [DIAGNOSES REDACTED] count, the more vulnerable you are to infectious diseases) and on reverse isolation (staff needs to wear gloves or other appropriate PPE to prevent bringing contaminants into the patient's room). After checking R14's blood sugar, LPN1 wiped the glucometer with an alcohol wipe and kept the glucometer in the cabinet in R14's room. In an interview with the DON on 6/11/20 at 4:23pm, when asked if the alcohol wipe was enough to disinfect the glucometer after use with a resident, the DON stated, Bleach wipes should be used (to disinfect the glucometer). Review of the facility's Cleaning and Disinfection of a Glucometer policy and procedure last revised 6/1/20, revealed under Guidelines: All glucometers will be cleaned and disinfected using a 1:10 bleach (sodium hypochlorite) solution or commercially prepared EPA (Environmental Protection Agency) germicidal (bleach) wipe. [MEDICATION NAME] alcohol will not provide disinfection and is not recommended. Further review of the same policy and procedure revealed under Procedure: .3. Wipe all external surfaces, including top, bottom and sides, using the bleach solution or commercially prepared EPA germicidal wipe. 2) Observation of LPN2, on 6/10/20 at 11:50am, revealed LPN2 used the Ultra Trak Complete glucometer to check R15's blood sugar in R15's room. Without using any barrier to protect the blood glucose test strip case, alcohol wipe, gauze and lancet from contamination by the surface of the medication cart and R15's over-bed table, LPN2 sat the blood glucose test strip case, alcohol wipe, gauze and lancet on top of the medication cart and R15's over-bed table. LPN2 got a paper towel where she sat the glucometer then sat the gauze and lancet on the liner after it had been contaminated by the surface of the medication cart and R15's over-bed table. After checking R15's blood sugar, LPN2 sat the glucometer on top of R15's puzzle book without using a barrier. LPN2 disinfected the glucometer appropriately but LPN2 did not disinfect the blood glucose test strip case. In an interview with the DON on 6/11/20 at 4:23pm, when told about the observation of LPN2 not using a barrier between surfaces and the blood glucose monitoring supplies, the DON stated, There should be a barrier (between surfaces and blood glucose monitoring supplies). Review of the facility's Blood Glucose Monitoring policy and procedure dated 1/23/20 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. B. Review of the current [DIAGNOSES REDACTED]. Review of the current [DIAGNOSES REDACTED]. 1) Observation of Nursing Assistant (NA1) and NA2, on 6/11/20 at 2:08pm, revealed NA2 used the pulse oximeter to check R16's, R17's, R18's, R19's, R20's and R21's vital signs (oxygen saturation level and pulse rate) in their rooms as NA1 was in-charge of documenting the vital signs. After using the pulse oximeter, NA2 was not observed disinfecting the pulse oximeter probe in between resident use. In an interview with NA1 and NA2 on 6/11/20 at 2:18pm, when asked when they should disinfect the pulse oximeter, NA1 stated, (The pulse oximeter is sanitized) after (they were) done with the hall, before other halls use it. In an interview with the DON and the Administrator on 6/11/20 at 4:16pm, when told about the observation and interview of NA1 and NA2 related to disinfecting the pulse oximeter, the DON and Administrator stated, (The pulse oximeter should be) sanitized in between (resident) use. 2) Observation on 6/11/20 at 2pm revealed that OT1 used the vital signs machine in R7's room. NA3 was observed wiping the bp (blood pressure) cuff and the pulse oximeter with the microdot bleach wipe for 10 seconds. In an interview with NA3 on 6/11/20 at 2:24pm, when asked how long were the bp cuff and pulse oximeter wet after she wiped them with the microdot bleach wipe, NA3 stated, It dries right away. Review of R7's current care plans revealed, Resident has presumptive potential Exposure to pathogen outside facility. On contact and droplet isolation (precautions) for 14 days post admission. 3) Observation of NA4 on 6/11/20 at 3:48pm, revealed NA4 used the pulse oximeter to check R22's vital signs in R22's room. After using the pulse oximeter, NA4 wiped the outer part of the pulse oximeter with a microdot bleach wipe for five seconds but did not disinfect the pulse oximeter probe which came in contact with the residents' skin. 4) Further observation of NA4 on 6/11/20 at 4:02pm, revealed NA4 used the pulse oximeter to check R23's vital signs in R23's room. After using the pulse oximeter, NA4 wiped the outer part of the pulse oximeter with a microdot bleach wipe for 15 seconds but did not disinfect the pulse oximeter probe which came in contact with the residents' skin. In an interview with NA4 on 6/11/20 at 4:03pm, NA4 verified that she only wiped the outer part of the pulse oximeter. When asked how long was the pulse oximeter wet after she wiped it with the microdot bleach wipe, NA4 stated, (It was) wet for 15 seconds. In an interview with the DON on 6/11/20 at 4:18pm, when told about the observation of NA3 and NA4 not sanitizing the medical devices after resident use with appropriate contact time, the DON stated, (They should) follow the contact time. According to the Microdot Bleach Wipes Directions for Use, A 30 second contact time is required to kill HBV ([MEDICAL CONDITION] virus) and HCV ([MEDICAL CONDITION] virus). A 3 minute contact time is required to kill [MEDICAL CONDITION] spores. A 5 minute contact is required to [MEDICAL CONDITION](human immunodeficiency virus) and other organisms listed on the label ([MEDICAL CONDITION]-resistant Staphylococcus aureus, Staphylococcus aureus, Pseudomonas aeruginosa, Salmonella [MEDICATION NAME]-resistant [MEDICATION NAME] faecalis and [MEDICATION NAME] mentagrophytes). Reapply as necessary to ensure that the surface remains wet for entire 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 the facility's Cleaning and Disinfection of Resident Care Equipment policy and procedure last revised 5/18/20 revealed under Procedure: 1. Reusable equipment will be cleaned and disinfected after use of one resident and before use of another resident. Further review of the same policy and procedure revealed, .3. Unless otherwise specified by manufacturer recommendations, reusable equipment will be cl</p>		