STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525265	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany St Joseph Care Ctr	2501 Shelby Rd LA Crosse, WI 54601

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 47657 Based on interview and record review, the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 1 resident (R59) reviewed for following physician orders. Findings: R59 was admitted to facility on 03/07/24 with diagnoses of hypertension, renal failure, and diabetes with neuropathy. On 03/20/24, occupational therapy placed a note in R59's chart indicating increased edema in bilateral lower extremities On 03/25/24, the physician conducted rounds for R59 and placed an order for Furosemide (a diuretic) 20mg daily to regimen, due to edema in bilateral lower extremities. On 03/28/24, R59 received a physician order for daily weights x 2 weeks then weekly due to bilateral lower extremity edema. The order was entered into R59's chart to obtain daily weights starting 3/29/24 through 04/11/24. On 04/24/24, Surveyor reviewed R59's recorded weights and noted facility failed to follow the physician order for daily weights for 11 days out of the 14-day period, obtaining only 3 weights on 04/02/24, 04/04/24, and 04/10/24. On 04/24/24 at 4:17 PM, Surveyor interviewed Director of Nursing (DON) B regarding the order for weekly weights and noted this had not been completed as ordered by physician. DON B stated a Performance Improvement Plan was just initiated as the order was placed for the certified nursing assistants to complete but was not followed through.

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.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40590 Based on observation, interview and record review, the facility did not ensure hand hygiene was conducted appropriately for 2 of 4 wound care observations (R32 and R65). This is evidenced by: The CDC had outlined the following indications for hand washing and the wearing of gloves: A. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, wash hands with either a nonantimicrobial soap and water or an antimicrobial soap and water. B. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations described in items. Alternatively, wash hands with an antimicrobial soap and water in all clinical situations described in items. C. Decontaminate hands before having direct contact with patients . F. Decontaminate hands after contact with a patient's intact skin. G. Decontaminate hands after contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings if hands are not visibly soiled. H. Decontaminate hands if moving from a contaminated-body site to a clean-body site during patient care. I. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. J. Decontaminate hands after removing gloves . The CDC continues to direct healthcare workers with the technique of hand hygiene: . E. Change gloves during patient care if moving from a contaminated body site to a clean body site . The facility policy, entitled Hand Hygiene, dated 03/12/24, states: Purpose: To prevent and control transmission of infections and illnesses to residents and among staff and visitors and Handwashing required: always wash hands before doing cares on residents, after cleaning feces or urine, after resident cares, between residents, after using the bathroom, before and after meals, before returning to work after break, after removing gloves, before leaving a resident room (isolation and standard), when hands are visibly soiled, after repeated sanitizations (more than 10), and when suspected Norovirus or GI illness is present. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, entitled Dressing Changes, dated 07/20/05, states: Purpose: This procedure will be used for all dressing changes unless otherwise indicated by the M.D. Procedure: 1. Gather equipment. 2. Wash hands - don gloves 3. Place two barriers down - one for clean and one for dirty. 4. Open dressing supplies and place on clean barrier 5. Remove old dressings-place in plastic bag or on dirty barrier. 6. If extremity needs to be soaked place basin on barrier and extremity in water. 7. Remove gloves and wash hands. 8. If necessary open sterile dressings, cleaning solutions, and dressings at this time onto the clean barrier. 9. Put on clean gloves. 10. If dressings need to be cut-use scissors found in the individual residents' dressing kit. 11. Cleanse area with no touch technique, cleaning from center of wound to a few inches outside the affected area in a circular motion, dropping used materials in a plastic bag or onto dirty barrier. 12. Remove gloves, wash hands, don clean gloves. 13. Apply ointments as ordered using appropriate applicator. 14. Apply dressing taking care not to touch the open area with gloves. If at any time your glove comes in contact with wound or drainage, you must remove the gloves, wash hands, and re-glove before handling any of the items on the clean barrier. 15. Apply tape or other materials. 16. Write date, time, and initials on tape. 17. Remove gloves and wash hands. 18. Close plastic bag and take to disposal area. 19. Wash hands. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	If you have more than one wound on the same resident-use the same procedure for each wound. R32 was admitted to the facility on [DATE] and has diagnoses that include diabetes mellitus type 2, peripheral vascular disease, history of cerebral vascular accident affecting left side, cognitive impairment, and morbid obesity. R32's Minimum Data Set (MDS) assessment, dated 03/11/24, indicates that R32 has a Brief Interview for Mental Status (BIMS) score of 04 (severe cognitive impairment). R32 has an Activated Power of Attorney (APOA). R32's wound assessments, dated 04/22/24, shows that R32 has a stage 4 pressure injury to the left outer thigh. This pressure injury has two openings that are connected by a 9.5-centimeter tunnel making them one wound. The lower wound area was created by a surgeon to allow for drainage after an abscess had formed. A Penrose drain was placed in the hospital on 11/29/23 and removed on 03/07/24. R32 also has a reddened area under the left breast with prescribed treatment. Hospital Discharge Summary, dated 12/05/23, states that necrotizing fasciitis was discovered to the lower leg compartment after surgical incision and draining was performed by a surgeon. Hospital discharge summary states that without further debridement of the necrotizing fasciitis, this wound will never heal. R32's APOA opted to not put R32 through the surgeries that would debride the necrotizing fasciitis and allow possible healing. R32 has physician orders as follows: Left thigh wounds: AM/PM 1. Use Q-tip to remove old alginate. Cleanse wounds with normal saline and gauze. 2. Gently/loosely pack both wounds to left thigh w/ calcium alginate silver strips (OK to use calcium alginate squares) Do NOT moisten calcium alginate. Pack calcium alginate into wound dry with Q-tip. 3. Triad to denuded/eroded areas of wound edges. 4. Triad to red irritated area and moisture associated skin damage (MASD) around wound and in between wounds. 5. Cover with ABD pad (blue line to the outside) and hold in place with brown tape. Change twice a day AM/PM if tolerating well. Left breast: cleanse area with normal saline. Frost with Triad. Place Viva for protection. Twice a day AM/PM if tolerating well. On 04/23/24 at 3:00 PM, Surveyor conducted a wound care observation of R32's left thigh and left breast wounds performed by LPN I. Registered Nurse (RN) J, who is currently training, was in the room assisting with holding and repositioning R32. LPN I and RN J donned personal protective equipment (PPE) appropriately (R32 is in enhanced barrier precautions). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN I sanitized her hands and set up a barrier with dressing supplies on a bedside table that included gauze, normal saline, Triad cream, Q-tips, tape, ABD bandage and box of gloves. LPN I placed the bedside table on the left side of R32's bed. RN J raised the bed, lowered the head of bed and positioned resident on her right-side facing doorway. Surveyor observed an ABD pad taped to the outer left thigh. LPN I donned gloves and placed a barrier pad under resident's left thigh/buttock area. LPN I removed old ABD bandage. Two areas were observed to the left thigh; one was close to the upper thigh buttock area (anterior) and the other was lower/mid-thigh (posterior). Both areas were packed with calcium alginate. The wounds appeared clean without signs of infection. LPN I used the long wooden stick end on Q-tip to remove the packing from the anterior wound and placed the packing on the old ABD pad. LPN I then used the same wooden end on Q-tip to remove the packing from the posterior wound. The waste was discarded in the garbage next to the bed. LPN I doffed her gloves and donned new gloves without washing or sanitizing hands. LPN I cleansed the wound areas with gauze soaked in normal saline. The skin area surrounding the wounds appeared scaly with dry patches. LPN I doffed gloves, discarded them, and donned new gloves without washing or sanitizing hands. LPN I opened a package of calcium alginate and used a clean pair of scissors to cut the alginate into strips. The strips were left on the inside of the calcium alginate package. LPN I then used a new Q-tip and with soft end packed the posterior wound and then packed the anterior wound. LPN I discarded Q-tip and alginate package, doffed gloves and discarded them. LPN I donned new gloves without washing or sanitizing hands. LPN I then applied Triad cream to the outer skin and peri-wound area excoriated skin. LPN I doffed gloves, discarded, and donned new gloves without washing or sanitizing hands. LPN I placed a new ABD pad over the area and secured with brown tape. LPN I dated and initialed the tape. LPN I gathered the barrier pad with waste and discarded, doffed gloves. LPN I did not wash or sanitize hands. RN J doffed gloves, discarded, used hand sanitizer, donned new gloves, and prepared R32 for the left breast dressing change. RN assisted R32 in holding up her left arm. LPN I donned new gloves without washing or sanitizing hands. LPN I exposed the area under left breast. This area was observed as pinkish red in color with no open areas. LPN I cleansed the area with gauze and normal saline then discarded waste. LPN I doffed gloves and donned new gloves without washing or sanitizing hands. LPN I applied Triad cream and a Viva cloth. LPN I doffed gloves and discarded in garbage. LPN I and RN J assisted R32 with repositioning and a boost up in the bed. Bedside table was next to resident's bed and call light attached to blanket within reach. R32's bed was then lowered. LPN I and RN J removed garbage and replaced bags. Waste was discarded in the garbage bin in room. LPN I and RN J doffed PPE, discarded and hand sanitized before leaving the room. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/24 at 4:01 PM, Surveyor interviewed LPN I regarding hand hygiene during R32's wound care. LPN I stated that LPN I should perform hand hygiene prior to performing the dressing change and then when completely finished, prior to putting gloves on and after taking them off, after taking off PPE and before leaving the room. 47284 Example 2 R65 was admitted to the facility on [DATE] and had diagnoses that included in part acute infective endocarditis, congestive heart failure (CHF), nonrheumatic aortic valve disorder, rheumatic mitral stenosis, pressure ulcer, anemia, severe protein calorie malnutrition, diabetes, malignant neoplasm of breast, and chronic kidney disease (CKD). R65's orders: Ensure that you use Unisolve to remove old dressing to promote skin integrity. Cleanse 4 stage 3 pressure injury (PI) to bilateral buttocks and 2 stage 2 PI with wound cleanser, pat dry. Apply small dab of Triad to wound beds. Spray peri-wound liberally with Cavilon. Allow to dry. Place a large Hydrocolloidal dressing cut in half to both side of gluteal cleft and coccyx ensuring that the wounds are covered. Do not secure with transparent dressing. Every three days and as needed (PRN). On 4/24/24 at 1:30 PM, Surveyor observed RN G perform wound care to R65's PIs. RN G performed hand hygiene and donned gown and gloves. RN G then cleansed the area with wound cleanser and gauze. RN G removed gloves; no hand hygiene was performed. RN G then put on new gloves, applied Triad to the wounds and then removed gloves; no hand hygiene was performed. RN G then put on new gloves and sprayed Cavilon spray to the wound and allowed to dry, applied hydrocolloidal to cover area and applied Triad around the hydrocolloidal dressing. RN G then removed gloves and used hand sanitizer. Hand hygiene should have been performed after each glove change. On 4/24/24 at 1:39 PM, Surveyor interviewed RN G and asked what the policy was for hand hygiene during wound care. RN G said hand hygiene before and after the start and stop of wound care. Surveyor asked RN G if when he changed gloves during the wound care, should he have performed hand hygiene. RN G said he was not sure and would have to ask the charge nurse what the standard of practice was. RN G said thinking about it, he should have used hand sanitizer after each glove change. On 4/25/24 at 8:29 AM, Surveyor interviewed the wound care nurse, RN H, and asked what the expectation for hand hygiene with glove change during wound care was. RN H said hand hygiene should be performed after each glove change. On 4/25/24 at 9:00 AM, Surveyor interviewed Director of Nursing (DON) B and asked what the expectation for hand hygiene with glove change during wound care was. DON B said hand hygiene should be performed after each glove change.

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47284

Based on observation, interviews and record reviews, the facility did not maintain an infection prevention and control program according to professional standards of practice when Enhanced Barrier Precautions (EBP) with appropriate Personal Protective Equipment (PPE) was not followed for 1 of 8 resident (R45) and lack of hand hygiene between glove changes during personal cares for 1 of 8 resident (R16).

This was evidenced by:

Example 1

The facility utilizes the Centers for Disease Control and Prevention (CDC) sign for EBP that states: Everyone must: .wear gloves and a gown for the following high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: urinary catheter .

The facility policy, entitled Enhanced Barrier Precautions, revised 4/05/24, states: .The use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of Multi Drug Resistant Organisms (MDRO)s to staff hands and clothing .Examples of high contact resident care activities requiring gown and glove use for EBP include [in part]: changing briefs or assisting with toileting, device care or use: urinary catheter .

R45 was admitted to the facility on [DATE] and had diagnoses that included in part retention of urine, neuromuscular dysfunction of bladder, dementia, and adrenal cortical insufficiency. R45 had a urinary catheter.

Outside R45's door was a PPE cart that included gloves and gowns, along with the CDC sign for EBP that stated, .wear gown and gloves when providing high contact resident care such as device care or use - urinary catheter or changing briefs or assisting with toileting .

On 4/23/24 at 10:00 AM, Surveyor observed Certified Nursing Assistant (CNA) D and CNA F perform personal care of changing brief and catheter care to R45. Both CNAs did not wear a gown during the brief change. CNA D cleaned R45's perineal area and then cleaned stool while CNA F was in direct contact with R45, holding R45 in place. When finished holding R45, CNA F applied gown and gloves to empty R45 catheter.

On 4/24/24 at 1:39 PM, Surveyor interviewed Registered Nurse (RN) G and CNA E and asked when to wear PPE of gown and gloves when a resident was on EBP. RN G and CNA E said to wear gown and gloves when doing high contact resident care such as wound care, catheter care, any personal care for residents who were on EBP.

On 4/25/24 at 8:29 AM, Surveyor interviewed RN H and asked what the expectation of EBP when to wear gown and gloves. RN H said anytime direct care is provided, the gown and gloves need to be worn.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/24 at 9:00 AM, Surveyor interviewed Director of Nursing (DON) B and asked what the expectation of EBP when to wear gown and gloves. DON B said anytime direct care is provided, the gown and gloves need to be worn. 47657 Example 2 Facility policy entitled Hand Hygiene revised on 03/12/24 states in part .Purpose: To prevent and control transmission of infections and illnesses to residents and among staff and visitors: Handwashing required: always wash hands before doing cares on residents, after cleaning feces or urine, after removing gloves. On 04/24/24 at 8:49 AM, Surveyor observed CNA C conduct cares on R16. CNA C donned clean pair of gloves and with assistance of the sit to stand lift, transferred R16 out of recliner which had a urine-soaked pad on the recliner. CNA C proceeded to pulled down R16's urine-soaked incontinence pad and pants. CNA C proceeded to do the following: Applied lotion to R16's legs/feet, removed gloves and donned clean pair of gloves, applied compression stockings, took clean incontinent pad and secured in place, dressed in clean pants to knees, cleansed abdominal folds, applied powder and dry paper towel in abdominal folds, brought lift and secured resident from toilet to lift to standing position, cleansed buttocks and pulled up clean pants and transferred R16 to w/c, and removed mechanical lift sling. CNA C continued to complete upper body cares and dressing on R16 and applied lipstick, touching R16's chin with unclean hands to apply the lipstick. CNA C then brushed R16's hair, placed oxygen tubing into nares and unwrapped a sucker per R16's request. CNA C donned clean pair of gloves and removed soiled clothing and garbage from room, after all of the other cares were done. On 04/24/24 at 9:34 AM, Surveyor interviewed CNA C, regarding education received regarding hand hygiene during cares. CNA C stated CNA C received education to use either hand sanitizer or wash hands after removing gloves, before and after cares. CNA C confirmed hand hygiene was not conducted during cares. On 04/24/24 at 11:28 AM, Surveyor interviewed DON B regarding observation of lack of hygiene during morning cares which included incontinence care. DON B stated the expectation would be after completing incontinence care to remove gloves and conduct hand hygiene.