STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015942	A. BUILDING: _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWICK CLINTON	306 OGDEN AVE CLINTON, WI 53525

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 09/26/2023, Surveyor conducted a complaint investigation and standard survey at Willowick Clinton. Two deficiencies were identified. The complaint was unsubstantiated. Census: 20	N 000		
N 441	83.39(3) Hand washing. Employees shall follow hand washing procedures according to centers for disease control and prevention standards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that employees followed hand washing procedures in accordance with the Centers for Disease Control and Prevention (CDC) standards. Caregiver C was not observed to conduct hand hygiene during the morning medication pass, from approximately 8:05 AM-8:21 AM and 8:25 AM-8:54 AM, which included administering medications to 6 residents. Findings include: The CDC instructs healthcare providers to complete hand hygiene after touching a patient or the patient's immediate environment as well as after glove removal (Source: CDC, Healthcare Providers Introduction to Hand Hygiene, January 8, 2021, https://www.cdc.gov/handhygiene/providers/index.html#:~:text=Alcohol%2Dbased%20hand%20san	N 441		

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

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N 441	Continued From page 1	N 441		

itizers%20are%20the%20preferred%20method%20for%20cleaning,and%20after%20using%20the%20restroom (retrieval date - September 27, 2023)).

On 09/26/2023 at 8:05 AM, Surveyor began observing Caregiver C during the morning medication pass. Between 8:05 AM and 8:54 AM, Surveyor observed Caregiver C administer medications from the medication cart to 6 residents including, Resident 1, Resident 2, Resident 3, Resident 4, Resident 5 and Resident 6. During Resident 1's medication pass, Surveyor observed Caregiver C assist Resident 1 with his/her inhaler without any gloves on, assist putting the cup of medications up to Resident 1's mouth, tilting the cup into his/her mouth, and walk back to the medication cart touching the door handle to enter the medication room. At 8:13 AM, Caregiver C was observed using keys to lock/unlock the medication cart to retrieve the blood pressure machine. Surveyor followed Caregiver C to Resident 2's room and s/he entered. Resident 2 was sleeping, and Caregiver C checked Resident 2's blood pressure while s/he was in bed. At 8:21 AM, Caregiver C returned to the medication room, and was observed grabbing medication cups from the stack, pouring water into a small cup, using keys to lock/unlock the medication cart, retrieve medication cards from the cart drawers, and pop medications into medication cup for Resident 2. Caregiver C returned to Resident 2's room where s/he was in their bathroom. Surveyor observed Caregiver C apply gloves to assist Resident 2 with toileting and administer medications while s/he was in the bathroom. Caregiver C was observed performing hand hygiene at this time. Between 8:05 AM-8:21 AM, Caregiver C was not observed conducting hand hygiene until assisting

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N 441	Continued From page 2	N 441		

with cares. At 8:25 AM, Caregiver C retrieved the blood pressure machine from the medication cart and checked Resident 3's blood pressure while s/he was seated in the dining room. Caregiver C returned to the medication room and started prepping Resident 3's medications while grabbing medication cups from the stack, pouring water into a small cup, using keys to lock/unlock the medication cart, retrieve medication cards from the cart drawers, and pop medications into medication cup. At 8:30 AM, Resident 3 was administered his/her medications in the dining room. At 8:33 AM, Caregiver C returned to the medication room and prepped Resident 4's medications while grabbing medication cups from the stack, pouring water into a small cup, using keys to lock/unlock the medication cart, retrieve medication cards from the cart drawers, and pop medications into medication cup. Resident 4 was administered his/her medications. At 8:42 AM, Caregiver C returned to the medication room and opened the medication cart by using keys to unlock/lock the medication cart. Caregiver C stated, "I have to ask Resident 5 his/her pain level prior to administering medications." Caregiver C went to Resident 5's room, s/he was not present, so Caregiver C found Resident 5 in the facility's common area off the dining room. Resident 5 reported his/her pain level as "8." Caregiver C returned to the medication room and prepped Resident 5's medication by grabbing medication cups from the stack, pouring water into a small cup, using keys to lock/unlock the medication cart, retrieve medication cards from the cart drawers, and pop medications into medication cup. While prepping Resident 5's medications, Surveyor observed Caregiver C donning gloves to prepare Resident 5's Spiriva inhaler. After doffing the gloves, Caregiver C moved to administering Resident 5's medications

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N 441	Continued From page 3 while s/he was in the common area of the facility at 8:49 AM. At 8:51 AM, Caregiver C returned to the medication room and prepped Resident 6's medications. At 8:54 AM, Resident 6 was administered his/her medications in the hallway next to the dining room. Between 8:25 AM-8:54 AM, Caregiver C was not observed to conduct hand hygiene during the observation period. On 09/26/2023 at 8:55 AM, Surveyor interviewed Caregiver C. Caregiver C asked, "how did I do?" Surveyor noted s/he did not observe Caregiver C conduct hand hygiene between residents. Caregiver C stated s/he knew hand hygiene was supposed to be conducted between each resident's medication administration. On 09/26/2023 at 1:15 PM, Surveyor interviewed Owner A and Administrator B. Administrator B stated s/he talked to Caregiver C earlier of his/her lack of hand hygiene during the morning medication pass. Administrator B reported when the facility nurse delegates staff to administer medications hand hygiene is reviewed and med passers are expected to conduct hand hygiene between each resident's medication administration.	N 441		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall	N 452		

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N 452	Continued From page 4 maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that food was stored under sanitary conditions for the prevention of food borne illnesses. Findings include: On 09/26/2023 at 7:49 AM, Surveyor toured the kitchen and observed the following: In the refrigerator, 1 gallon container of Italian dressing (approximately ¼ full) was observed undated, 1 large Ziploc baggy of American cheese was observed without a label and undated, 1 case of 20lb broccoli almost full was observed unsealed and with the top of the box open, and 4 small dishes containing peach halves was observed undated. In the pantry room, 1 gallon container of Italian dressing (approximately ¾ full) was observed opened and the directions "refrigerate after opening" was observed on the side of the container, 1 large Ziploc baggy full of flour was observed open and unsealed, and one pound bag of pretzels was observed open and unsealed. In the freezer, 1 bag of pita flat breads was	N 452		

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N 452	Continued From page 5 observed open and unsealed. In the cabinets, 2 bags of cereal (approximately ¼ full) was observed open and unsealed, 1 bag of gold fish (approximately ½ full) was observed open and unsealed, and 2 bags of potato chips was observed open and unsealed. On 09/26/2023 at 1:15 PM, Surveyor interviewed Owner A and Administrator B. Administrator B stated s/he talked to staff earlier about the importance of sealing opened food and dating. Administrator A acknowledged it's an ongoing reminder for staff.	N 452		