**STATE OF WISCONSIN/DEPARTMENT OF HEALTH SERVICES**

**DIVISION OF QUALITY ASSURANCE**

**Issues cited at F880 in 2018**

(Review of 156 citations)

* Failure of CNAs to wash hands or change gloves when appropriate during personal cares. 61
* Failure of nurses to wash hands or change gloves when appropriate during treatments. 40
* Contamination of medications during med pass. 20
* Shared glucometer not disinfected between use: 19
* Did not calculate rates of infection to analyze trends. 18
* Not reporting CRE: 18
* Line list did not contain all residents with potential infections (most because only included ATB). 14
* Line list incomplete (doesn’t track all needed information). 14
* Not wearing personal protective equipment when indicated. 13
* Did not clean or sanitize equipment. 9
* Did not promptly identify onset date of an infectious outbreak: 7
* Inappropriate handling/disposing of soiled linens. 5
* Tracking form did not identify staff well dates. 5
* Surveillance tracking form did not track or trend infections. 5
* Did not place barrier between surface and equipment. 5
* Improper hygiene while feeding residents (touching food, wiping mouth, coughing): 4
* Timely cultures not completed prior to use of antibiotics: 4
* During an outbreak, did not restrict staff movement between units. 4
* Oxygen tubing/cannula allowed to drag on floor then placed back on resident: 4
* Catheter bag or tubing allowed to drag on floor: 3
* During an outbreak, did not implement enhanced cleaning or use appropriate sanitizer: 3
* Housekeeping not washing hands as appropriate: 3
* Resident not in contact precautions when should have been. 3
* Staff worked when ill. 3
* Did not have appropriate signage on doors of residents with precautions: 2
* Not properly disposing of personal protective equipment after leaving room. 2
* During an outbreak, staff did not change dirty mop heads. 2
* During an outbreak, facility did not suspend group activities: 1
* Did not clean shared bathrooms after used by a resident with c-diff. 1
* Commingled personal care items. 1
* Did not sanitize CPAP equipment. 1
* Did not complete/perform peri-care as needed: 1
* Did not start treatment with antiviral as ordered: 1
* No TB testing prior to admission of residents
* Did not ensure dishwasher was properly sanitizing dishes during an outbreak: 1
* No schedule for cleaning a resident’s personal humidifier: 1