STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145979	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GIBSON COMMUNITY HSP ANNEX	430 EAST 19TH GIBSON CITY, IL 60936

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview the facility failed to prevent cross contamination during wound care by using contaminated gloves to provide wound care for one (R13) of two residents reviewed for wound care in a sample list of 13 residents. Findings include: R13's Physician order [REDACTED]. This same POS also documents [REDACTED]. R13's Care Plan documents R13 as frequently incontinent and at risk for skin breakdown due to limited mobility, incontinence and need for staff assistance with bed mobility and positioning. Minimum Data Set (MDS) for R13 dated 1-29-2020 documents a Brief Interview for Mental Status (BIMS) score of 5 out of a possible 15 points (severely cognitively impaired). This same MDS documents R13 requires extensive assistance of two staff for bed mobility, transfers and toileting. On 03/11/20 at 10:40 AM V3, Licensed Practical Nurse completed wound care for R13's open inner Right Buttock Boil recently infected [MEDICAL CONDITION] and R13's open areas on inner Left Buttock. R13 was standing in front of commode that contained moderate sized bowel movement with back of R13's legs touching front of commode chair. Commode had not been emptied nor cleaned. R13 became tired after V3 cleansed R13's inner buttock wounds and sat down on soiled commode seat. R13 again stood to complete wound care. With gloved hands, V3 used V3's third finger on right hand to apply aloe/calmo cream to R13's open inner right buttock boil and then without changing gloves, washing hands or using Alcohol Based Hand Rub (ABHR), V3 used same contaminated gloved finger to apply aloe/calmo cream to open inner left buttock wounds. On 3/11/2020 at 11:00 AM V3 stated should have cleansed commode bucket before attempting treatment for [REDACTED]. V3 stated should treat each wound individually to prevent cross contamination of wounds. On 3/11/2020 at 3:30 PM V2, Director of Nurses stated nurses should treat one wound at a time in order to prevent cross contamination during wound care. The facility policy titled Wound Care Observation Checklist for Infection Control which is undated documents the following: 1. Multi-dose wound care medications (ointments, creams) should be dedicated to a single resident whenever possible or a small amount of medication should be aliquoted into a clean container for single-resident use; 2. Gloves should be changed and hand hygiene performed when moving from dirty to clean wound care activities. 4. Aseptic non-touch technique refers to a procedure that aims to prevent the transmission of microorganisms to the wound. Clean gloves should not directly come in contact with the wound bed. Sterile applicators should be used to apply medications. 5. In addition to reusable medical equipment, any surface in the patient/resident's immediate care area contaminated during a dressing change should be cleaned and disinfected.
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** Based on record review, observation and record review the facility failed to prevent cross contamination during wound care for a Stage II pressure wound on one (R165) resident out of two residents reviewed for wound care in a sample list of 13 residents. Findings include: Physician order [REDACTED]. R165's Care Plan documents a Stage II pressure ulcer on left buttock. Minimum Data Set ((MDS) dated [DATE] documents R165's Brief Interview for Mental Status (BIMS) score of 9 out of a possible 15 points which indicates moderately cognitively impaired. This same MDS also documents R165 as requiring limited assistance of one staff for bed mobility, transfers, toilet use and personal hygiene. On 03/11/20 at 9:10 AM V3, Licensed Practical Nurse completed pressure wound care for R165's Stage II pressure ulcer on left buttock. V3 placed wound cleanser, gauze and physician ordered cream on back of bathroom sink in R165's bathroom. V3 did not clean sink off or place clean towel down to create clean field before placing wound supplies on back of contaminated sink. V3 touched R165's buttocks including open pressure ulcer on left buttock then wearing same contaminated gloves and without washing hands, changing gloves or using Alcohol Based Hand Rub (ABHR), picked up gauze and cleansed R165's left buttock pressure ulcer with contaminated gauze. On 3/11/20 at 9:25 AM, V3 stated staff should provide a clean field for supplies when completing wound care. V3 also stated should have changed gloves, used ABHR, or washed hands between touching R165's open wound and using wound supplies. On 3/11/20 at 3:35 PM V2, Director of Nursing stated nurses should provide clean field for wound supplies when completing wound care. V2 also stated staff should change gloves, wash hands or ABHR when moving from a contaminated area to a clean area to prevent cross contamination. The facility policy titled Pressure Injury/Skin Tear Management revised 7/19 documents the following: Procedure: Disinfect the resident's bedside table with disinfectant wipe. Place supplies on the clean table. Trying to arrange them according to order of use to avoid any cross contamination. The facility policy titled Hand Hygiene-CDC (Centers for Disease Control) Guidelines revised 4/19 documents the following: Policy: All staff shall use the hand-hygiene techniques, as set forth in the following procedure. Hand hygiene consist of either use of soap and water or ABHR. Follows are times when hand hygiene must be performed: *After coming in contact with patient's intact skin. *After coming in contact with bodily fluids, dressings, etc., and hands are not visible soiled. If hands are not visible soiled, hands may be disinfected with either an ABHR or soap and water. Notes: Always follow Standard Precautions.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview the facility failed to provide complete incontinence care for one (R1) resident reviewed for incontinence care in a sample list of 13 residents. Findings Include: R1's Face Sheet documents [DIAGNOSES REDACTED]. R1's Care Plan documents R1 is frequently incontinent and needs assistance with hygiene and perineal care. Minimum Data Set ((MDS) dated [DATE] documents R1 as requiring extensive assistance of two staff for toileting. This same MDS documents R1 as being frequently incontinent of urine. R1's Physician order [REDACTED]. V4 placed no rinse foam cleanser on disposable wipe and wiped R1's perineal area one time while R1 was standing with V4 standing behind R1. V4 cleansed R1's perineal area by approaching from R1's backside. V4 did not approach R1 from the front. V4 without changing gloves, using Alcohol Based Hand Rub (ABHR) or washing hands then used a second disposable wipe to rinse R1's perineal area. Approximately quarter sized saturated area of brown substance observed on both wipes after V4 wiped R1's perineal area. V4 used each of the two disposable wipes to wipe one time with each wipe. V4 did not cleanse inner perineal area. V4 did not dry perineal area. On 3/11/2020 at 12:50 PM V4 stated should have provided complete incontinence care but could not due to V4 could not see area to be cleansed. V4 stated should use skin cleanser on outer perineal area and folds of inner perineal area and should dry area thoroughly when performing complete incontinence care. On 3/11/2020 at 3:40 PM V2, Director of Nursing stated staff should provide complete incontinence care including thorough cleansing of outer and inner perineal area followed by thorough drying of perineal area. The facility policy titled Foley Catheter/Perineal Care revised

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 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) 10/15 documents the following: Female patient: Clean sides of labia first in downward motion, washing from front to back with soap and water or no rinse soap. Separate labia with one hand and wash with other, using gentle downward [MEDICAL CONDITION] from the front to the back, using a clean section of the washcloth with each stroke. Avoid cleaning the rectum at the same time as the vagina to avoid contamination of the urethra or vagina. Using a clean washcloth, gently rinse the vaginal area and pat dry with a clean, dry towel. Turn patient on side, cleanse rectum with clean wash cloth using soap and water or no rinse soap. Use front to back motion, using clean area of cloth with each stroke. Use clean wash cloth to rinse and a clean towel to gently pat dry area.