STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145601	A. BUILDING _____ B. WING _____	05/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVISTON COUNTRYSIDE MANOR	450 WEST 1ST STREET AVISTON, IL 62216

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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, policy review, training records, and manufacturer's instructions, the facility failed to ensure point of care equipment was disinfected and staff hand hygiene was performed between resident contact for nine of nine resident's (R) 6, R7, R8, R9, R10, R11, R12, R13, R14) out of 30 residents on Cedar hall. This failure had the potential to spread infectious organisms to other residents who encountered the contaminated point of care equipment and/or staff, that failed to perform hand hygiene after caring for residents. Findings include: Observation on 05/14/20 at 2:38 PM showed Certified Nurse Aide (CNA) 4 exited room [ROOM NUMBER] and entered room [ROOM NUMBER]. An alcohol-based hand rub (ABHR) dispenser was observed on the wall outside room [ROOM NUMBER]. CNA4 was not observed to use it. At 2:40 PM, CNA4 exited room [ROOM NUMBER] carrying a clipboard, no touch scan type thermometer, and a (fingertip) pulse oximeter (used to measure oxygen saturation in a resident's blood). She then entered room [ROOM NUMBER] to take vital signs of an unidentified resident, who was partially obscured by a curtain. CNA4 then took the roommate, R6's, temperature (with a no-touch forehead thermometer) and oxygen saturation, using the same pulse oximeter. CNA4 removed the pulse oximeter from R6's finger and exited the room. The aide did not sanitize or disinfect the pulse oximeter or sanitize or wash her hands between the residents or after exiting room [ROOM NUMBER], and directly entering room [ROOM NUMBER]. CNA4 entered room [ROOM NUMBER] and used the same pulse oximeter on both R7 and R8. She did not clean or disinfect the pulse oximeter between the residents in the room. CNA4 also did not perform any type of hand hygiene between the residents in the room. Upon removing the pulse oximeter from R8, CNA4 dropped the device on the floor. She then picked up the device and exited the room. The aide also did not sanitize or disinfect the pulse oximeter, nor did she sanitize or wash her hands after exiting room [ROOM NUMBER]. CNA4 entered room [ROOM NUMBER] at 2:47 PM, after obtaining a cart containing an electronic blood pressure monitor from another staff member in the hallway. CNA4 took R9's vital signs using the blood pressure monitor, the thermometer, and pulse oximeter, which had been placed on R9's overbed table, with the clipboard. The aide did not clean the table prior to its use or utilize a barrier under the clipboard. After completing R9's vital signs (including temperature and oxygen saturation), CNA4 used PDI Super Sani-Cloths Germicidal Disposable Wipes on the blood pressure monitor, cuff, tubing and cart basket; but not the pulse oximeter. At 2:52 pm, CNA4 completed a temperature and oxygen saturation for R10, then exited the room. She did not clean or sanitize the pulse oximeter nor wash or sanitize her hands before or after leaving the room. At 2:54 PM, CNA4 entered room [ROOM NUMBER]. While in the room she laid the clipboard, the thermometer and the pulse oximeter on R11's bed, while she removed a blanket from over the resident. She then applied the same pulse oximeter to R11's finger and took the resident's temperature. At 2:56 PM, CNA4 went to R12, who resided in the same room, and applied the same pulse oximeter to the resident's finger. The aide also took the resident's temperature, then exited the room. The aide did not clean or disinfect the pulse oximeter. She also did not wash or sanitize her hands prior to or after leaving the room [ROOM NUMBER]. At 2:58 PM, CNA4 entered room [ROOM NUMBER], and applied the same pulse oximeter and checked the temperature of R13. She exited the Room at 3:00 PM and followed R14 down the hallway to room [ROOM NUMBER]. After entering the room, CNA4 laid the clipboard, with the thermometer and pulse oximeter, onto R14's chairside table, while performing a blood pressure. She then completed the temperature and oxygen saturation. CNA4 cleaned the blood pressure monitor, and its basket and left the room. She did not clean or sanitize pulse oximeter or wash or sanitize her hands prior to or after exiting the room. In an interview on 05/14/20 at 3:24 PM, CNA4 stated she had received education from the facility on hand hygiene between resident contacts about two months prior. When asked about the education regarding the cleaning of point of care equipment, such as the blood pressure monitor and pulse oximeter, CNA4 stated Not between residents, She clarified that the facility had not educated staff to clean/disinfect pulse oximeters between resident use. Review of the facility In-service Sign In Sheet, dated 3/11/20, which had the Illinois Department of Public Health training attached, stated Ensure employees clean their hands according to CDC (Centers for Disease Control) guidelines including before and after contact with residents, after contact with contaminated surfaces or equipment, and after removing protective personal equipment (PPE) .Training should include information on cleaning and disinfection practices. Review of the 05/03/20 public health COVID-19 - Long Term Care Facilities Guidance training, attached to the sign in sheet, showed CNA4 attended the training titled Re: PPE/Donning (putting on)/Doffing (taking off)/Handwashing/Social Distancing. Review of the facility policy, Covid-19 Preparedness, dated 05/11/20, page six stated: Hand Hygiene using Alcohol Based Hand Sanitizer (ABHS) before and after all patient contact, contact with infectious material and before and after removal of PPE, including gloves . If hands are soiled, washing hands with soap and water is required for at least 20 seconds. Ensure ABHS is accessible in all resident-care areas including inside and outside resident rooms, including common areas and other resident care areas. If not available, ensure that trash cans, soap and paper towels are readily available at all handwashing sinks. . If equipment must be used for more than one resident, it will be cleaned and disinfected before use on another resident, according to manufacturer's recommendations using EPA-registered disinfectants against COVID-19: . In an interview on 05/14/20 at 4:00 PM, the Director of Nursing (DON) responded to a query regarding employee hand hygiene stating, Germ In and Germ Out, (clarified to mean Germ-X, the facility brand of ABHS) between every room and in between each resident. The DON stated resident equipment was to be sanitized with MicroKill One, that has a one-minute kill time. The DON said .we also have a silver top wipe that has a two-minute kill time. She couldn't remember the name of the product. In an interview on 05/14/20 at 4:25 PM, when asked about the in-services, the Nursing Home Administrator (NHA) stated It's noted (on the form) but I verified with the DON (that) at the 03/11/20 in-service I went over what to disinfect, how to disinfect equipment and when it is to be done.

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.