STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145994	A. BUILDING _____ B. WING _____	**06/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INVERNESS HEALTH & REHAB	**1800 COLONIAL PARKWAY INVERNESS, IL 60067**

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 -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their infection control policy and practice by staff not performing hand hygiene in between residents' contact, before entering isolation room and after removing gloves coming out of droplet precaution room. This deficient practice can affect 5 out of 5 residents (R3, R5, R6, R7, R8, R9, and R10) reviewed for infection control practice to reduce the transmission of COVID-19. The facility also failed to follow their infection control protocol to include the use of a disinfectant spray (sodium hypochlorite) remained wet/contact time of at least 10 minutes to ensure the efficacy of the disinfectant on common area surfaces for 2 of 4 residents (R2,/R5) reviewed for efficacy of disinfectant for infection control Findings Include: On 6/4/2020 at 10:05am, V5 (housekeeping) is observed wearing gloves and a face mask only as she cleans R3's room. V5 is observed mopping the floor and emptying the garbage. V5 is observed removing gloves and discarding in garbage. On 6/4/2020 at 10:10am, V5 is observed entering R3's room to clean. R3 is on droplet transmission based isolation. Prior to entering R3's room, hand hygiene is not performed. V5 is observed wearing only a face mask and gloves while cleaning R3's room. On 6/4/2020 at 10:14am, V5 is observed exiting R3's room and don an isolation gown and then return to cleaning R3's room. On 6/4/2020 at 10:25am, V5 is observed exiting R3's room, removing gown and gloves and discarding. No hand hygiene is observed. V5 dons new isolation gown and gloves and proceeds to the next resident isolation room to clean. On 6/4/20 at 10:50am, V5 (Housekeeping) observed coming out of R10's room. R10 is on droplet precaution room, V5 removed gloves and gown. V5 did not perform hand hygiene, pushed housekeeping cart and parked outside R5's room at approximately 10:55am, donned gown and gloves and entered R5's room (also droplet precaution room). Continued to clean surfaces in R5's room. Upon leaving R5's room, V5 removed gown and gloves. V5 again, did not perform hand hygiene. V5 continued to push housekeeping cart and stopped outside R9's room at approximately 11:15am. V5 then donned gown and gloves and entered R9's room. V5 continued to clean surfaces in R9's room, while R9 in bed. On 6/4/20 at 12:00pm, attempted to interview V5. V5 stated, No speak English. On 6/4/20 at 12:10pm, V4 (Housekeeping Manager) stated, My staff are expected to do hand hygiene before entering and after leaving resident's room. They have hand sanitizer in their cart available for them to use. They have to wash hands before and after using gloves. Hygiene is important to prevent the spread of infection. On 6/4/20 at 12:45pm, V3 (ADON) stated, Staff must perform hand hygiene before and after using gloves. This is our practice to prevent [MEDICAL CONDITION] from spreading. On 6/4/20 at 12:15pm, observed residents sitting on individual dining room tables (main dining room for lunch observation). Observed V7 attended to R7. V7 removed the face mask of R7, making skin contact to R7's ears. V7 then placed the mask of R7 into a paper back. After placing the paper bag on back side of R7's wheelchair. V7 did not perform hand hygiene in between residents, and continued to assist another resident, R6. V7 then removed R6's face mask from R6's ears. V7 placed the mask inside a paper bag. V7 again did not perform hand hygiene. On 6/4/20 at 12:20pm, observed V8 removed the face mask of R8, touching R8's ears and placing the mask inside a paper bag. V8 did not perform hand hygiene in between residents contact and continued to assist another resident, R4, in removing face mask. V8 touched R4's ears when removing the mask, and there again V8 did not perform hand hygiene. On 6/4/20 at 12:30pm, V2 (DON) stated, Staff are supposed to do hand hygiene in between residents contact. I will talk to the staff On 6/4/20 at 12:45pm, V3 (ADON) stated. I am aware of the situation, my DON informed me that the staff did not wash their hands in between residents. I will make sure the staff are aware to perform hand hygiene after making contact with the resident and I will have staff replace the mask and provide residents with new masks. Handwashing/Hand Hygiene policy with a revised date of 3/2018 read in parts: The facility considers hand hygiene the primary means to prevent the spread of infection. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations. after contact with a resident's intact skin, before and after entering isolation precaution setting, before and after direct contact with residents, after removing gloves. Hand hygiene is the final step after removing and disposing of personal protective equipment On 6/4/2020 at 9:58am, V9 (housekeeping) is observed spraying disinfectant on hand rails and door knobs. On 6/4/2020 at 1:58pm, V9 is observed returning to units 700-800-900 to spray high touch surfaces with disinfectant spray. V9 is observed spraying the metal railing attached to 1/2 wall barrier separating TV room from hallway, round table in TV room, handrails along the walls, door knobs to resident rooms. V9 is observed spraying within the employee lounge, hallway bathroom door knobs, and the water fountain. On opposite side of the nurses' station are a total of 5 bookcases filled with books; 4 are located together, the 5th one is located on opposite side, to the right of the fireplace. V9 sprays the top of the book cases as well as the books in book cases 1, 2, 3, and 5. V9 is observed to spray around items on the counter at the nurses' station; including one tray containing with a pitcher of pale yellow liquid and individually wrapped cookies, 2 hard cover books, one resident chart, 5 clear picture frames with signage, and 3 small plants. V9 does not spray the contents of the 4th book case (located just to the left of the fireplace). V9 did not spray the couch where R5 had been sitting or the table next to couch in the TV room. V9 was not observed spraying any of the counters or cabinets within the nurses' station. On 6/4/2020 at 2:04pm, this surveyor observed metal surfaces that were recently sprayed to be dry after 4-6 minutes. Hand rails and book cases were observed to have blotchy areas of disinfectant still present. On 6/4/2020 starting at 9:58am, R2 is observed sitting in wheelchair at nurses' station. R2 is observed touching objects on the counter and the shelves. R2 is observed removing items from bags, then replacing, and then placing bags back on shelves. R2 is observed touching her face as well as wheelchair seat and wheels. On 6/4/2020, throughout this survey, this surveyor did not observe any staff member disinfecting the counters or cabinets at the nurses' station. This surveyor also did not observe any staff member offer to assist R2 with hand hygiene prior to eating meal. On 6/4/2020 at 1:30pm, V4 (housekeeping manager) stated that all high touch surfaces are sprayed every 2 hours from 6:00am to 8:00pm. V4 stated that housekeeping is responsible for spraying the shower rooms, hand rails, door knobs, bathrooms, and dining rooms. V4 stated that the disinfectant spray has a contact time of 10 minutes. V4 stated that the nursing staff is responsible for disinfecting the nurses' station. On 6/4/2020 at 1:35pm, V3 ADON (assistant director of nursing) stated that high touch surfaces throughout this facility are sprayed with a disinfectant every 2-3 hours. V3 stated that the nursing staff is responsible for disinfecting the nurses' station at the end of their shifts. V3 stated that housekeeping staff are responsible for disinfecting the nurses' station throughout the day. Review of the manufacturer's recommendations, the disinfectant cleaner should have a 10 minute contact time in order to be effective against coronavirus. A review of the EPA list N notes that sodium hypochlorite requires a contact time of at least 10 minutes to be effective against [DIAGNOSES REDACTED]-COV2 (COVID-19).

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