STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145621	A. BUILDING _____ B. WING _____	05/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PAVILION OF WAUKEGAN	2217 WASHINGTON STREET WAUKEGAN, IL 60085

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 and record review the facility failed to properly prevent the spread of infections such as COVID-19 as evidenced by failures to: (1) ensure that blood pressure (BP) cuff shared among residents was properly cleaned and disinfected after resident use for two (R1 and R2) residents; (2) follow infection control practices related to the use of glucometer (medical device used to measure sugar levels in the blood) for two (R3 and R4) residents; (3) ensure clean linens were handled to prevent contamination for one (R5) resident and 11 (R1, R2, R6, R7, R8, R9, R10, R11, R12, R13 and R14) residents who eat in the second floor dining room; (5) perform hand hygiene when appropriate after checking the vital signs of one (R15) resident; and, (6) perform hand hygiene when delivering meal trays for twelve (R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26 and R27) residents. Findings include: 1.A. Observation of Nursing Assistant (NA)1, on 5/5/20 at 3:41pm, revealed NA1 used the BP cuff to check R1's BP in the dining room. After using the BP cuff, NA1 wiped the BP cuff with an alcohol wipe. B. After checking R1's BP, NA1 used the unsanitized BP cuff to check R2's BP who was also in the dining room. NA1 wiped the BP cuff with an alcohol wipe after use with R2. In an interview with the Director of Nursing (DON) on 5/5/20 at 5:56pm, when told about the observations of nursing staff not appropriately sanitizing the BP cuff after resident use, the DON stated, They should use bleach wipes (to sanitize BP cuff). Review of the facility's Noncritical Patient Equipment Decontamination policy and procedure revised 2/23/20 revealed under Procedure: .3. Clean and disinfect the equipment using a cloth/wipe with a 1:10 to 1:100 concentration of bleach or EPA registered disinfectant . According to the Infection Preventionist's Guide to Long-Term Care published by the Association for Professionals in Infection Control and Epidemiology, Inc. (APIC) in 2013 revealed on page 166 under Maintaining Equipment, All equipment approved for use in the LTCF (Long Term Care Facility) must be cleaned and disinfected according to manufacturer instructions and included in the facility's policies and procedures .All equipment policies should contain the following essential infection prevention elements: Immediately clean/disinfect all equipment with the facility-approved EPA (Environmental Protection Agency) hospital grade disinfectant when visibly soiled or after use with residents .Always follow manufacturer's cleaning and disinfection recommendations . Review of Ten Tips for Cleaning and Disinfecting Shared Medical Equipment sent by Medline on January 29, 2010 to Medline customers revealed, .7. If no visible organic material is present, disinfect the exterior surfaces after each use using a cloth or wipe with either an EPA-registered detergent/germicide with a turberculocidal or HBV/HIV label claim, or a dilute bleach solution of 1:10 to 1:100 concentration . 2. Review of R3's and R4's current [DIAGNOSES REDACTED]. In addition, some diabetes-related health issues, such as nerve damage and reduced blood flow to the extremities, increase the body's vulnerability to infection.). A. Observation of Licensed Practical Nurse (LPN)1, on 5/5/20 at 4:04pm, revealed LPN1 used the Ultra Trak Complete glucometer to check R3's blood sugar in R3's room. Without using any barrier to protect the basket of blood glucose monitoring supplies from contamination by the surface of R3's over-bed table, LPN1 sat the glucometer and the basket of supplies on top of R3's over-bed table. After checking R3's blood sugar, LPN1 put the contaminated glucometer back in the basket of blood glucose monitoring supplies without cleaning and disinfecting the glucometer. B. Continuous observation of LPN1 on 5/5/20 at 4:15pm, revealed LPN1 used the contaminated glucometer to check R4's blood sugar in R4's room. Without using any barrier to protect the basket of blood glucose monitoring supplies from contamination by the surface of R4's over-bed table, LPN1 sat the basket of supplies on R4's over-bed table. After checking R4's blood sugar, LPN1 put the glucometer back in the basket of blood glucose monitoring supplies without cleaning and disinfecting the glucometer. LPN1 stored the contaminated basket of blood glucose monitoring supplies in the first floor medication/supply room without cleaning and disinfecting the basket of supplies and the glucometer. In an interview with the DON on 5/5/20 at 6pm when told about the observation of nursing staff setting the basket of blood glucose monitoring supplies and the glucometer on residents' over-bed tables without using any barrier use, the DON stated, (Nursing staff should put a) paper towel on the table for the basket of supplies and glucometer. When asked if the glucometer and the basket of supplies needed to be sanitized, the DON stated, He should have sanitized (the glucometer and the basket of supplies) with bleach wipes. Review of the facility's Cleaning and Disinfecting Blood Glucose Meters policy and procedure dated 4/21/20 revealed under Policy: It is the policy of the facility to clean and disinfect multi-patient use blood glucose meters. Resident to resident transmission of blood-borne pathogens is a well-known risk when using lancets, needles, and syringes. Blood glucose monitors that are shared among residents must be cleaned and disinfected between each use. Further review of the same policy and procedure revealed under Procedure: .4. When at the bedside, place a barrier (such as paper towel) between the blood glucose meter and surface - if setting meter down .8. Thoroughly clean all visible soil or organic material (e.g., blood) from glucometer before disinfection .10. Follow manufacturer's guidelines for cleaning and disinfecting of glucose meters. Specific guidelines for glucose meters may vary with the manufacturer . The same policy and procedure further indicated under Key Point: CDC (Centers for Disease Control and Prevention) Infection Prevention with the Blood Glucose Meters, .If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents . According to the Ultra Trak Complete Reference Manual, under Aftercare: Clean the Ultra Trak Complete Blood Glucose Meter between patient tests . Further review of the reference manual revealed under Cleaning: The Ultra Trak Complete should be cleaned and disinfected between each patient test . The reference manual further indicated under Procedure: .2. To clean the meter, take an alcohol pad or cleaning wipe and wipe down the body of the meter .3. To disinfect the meter, refer to the product label of the disinfectant wipes to determine how long the liquid from the wipes needs to be on the body of the meter for full disinfecting (also known as contact time) .5 .ensure that the meter has been both cleaned and disinfected between each use . According to a Centers for Disease Control and Prevention (CDC) article titled, Guidelines for Environmental Infection Control in Health-Care Facilities published on 6/6/03 under Recommendations - Environmental Services on subsection Cleaning and Disinfecting Strategies for Environmental Surfaces in Patient Care Areas, .3. Use barrier protective coverings as appropriate for noncritical surfaces that are 1) touched frequently with gloved hands during the delivery of patient care; 2) likely to become contaminated with blood or body substances . 3.A. Observation on 5/5/20 at 3:33pm revealed Nursing Assistant2 (NA2) was in the hallway handling linens and was oberved holding them against her uniform. NA2 went to R5's room with another NA. In an interview with NA2 on 5/5/20 at 3:49pm, NA2 verified that she brought an incontinence brief and a draw sheet in R5's room. NA2 further stated, R5 had a bowel movement so we cleaned him up. When asked if she should have held clean linens against her uniform, NA2 stated, (I was) not supposed to. It should be carried away from our uniform. B. Observation on 5/5/20 at 3:55pm revealed a laundry aide (E1) was delivering clean clothing protector to the second floor dining room and was holding them against her uniform. In an interview with E1 right after the observation, E1 stated, They were about to fall so instead of letting them fall and rewashing them downstairs, I held them close to my body. When asked if she should have held the clean clothing protectors against her uniform, E1 stated, No, I should not. Review of the requested list of residents who ate in the second floor dining room provided by the facility on 5/7/20 at approximately 9:08am, revealed that 11 (R1, R2, R6, R7, R8, R9, R10, R11,

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) R12, R13 and R14) residents eat in the second floor dining room. Review of R8's, R11's and R12's current [DIAGNOSES REDACTED]. Review of R9's, R11's, R12's and R13's current [DIAGNOSES REDACTED]. In an interview with the DON on 5/5/20 at 5:58pm, when told about the observations of NA2 and E1 holding clean linens and clothing protectors against their uniform, the DON stated, (The staff should make sure that clean linens) don't touch(their) uniform. (It is) not acceptable. (The) uniform (is) not clean. Review of the facility's Handling Clean Linen policy and procedure dated 1/20/20 revealed under Important Points, .Carry linen away from your body and uniform . 4.A. Observation of NA1 on 5/5/20 at 3:25pm revealed that NA1 was checking R15's vital signs (BP, pulse rate, temperature and oxygen saturation level) in R15's room. After checking R15's vital signs, NA1 removed her gloves before leaving R15's room but did not wash her hands. In an interview with NA1 immediately after the observation when asked if she should have washed her hands after removing her gloves, NA1 stated, I forgot (to wash my hands). Review of R15's current [DIAGNOSES REDACTED]. In an interview with the DON on 5/5/20 at 5:49pm when told about the above observation, the DON stated, She should wash her hands. B.1) Observation on 5/5/20 at 5:05pm revealed that NA1 brought dinner trays to R16's and R17's rooms. NA1 was wearing gloves and was not observed performing hand hygiene before delivering the dinner trays to the two rooms. NA1 assisted in setting up the residents' meals on the residents' over-bed tables in their rooms. Review of R16's and R17's current [DIAGNOSES REDACTED]. Further review of R16's current [DIAGNOSES REDACTED]. The Unit Manager used the Pro-Care wipes (Personal Wipes that are alcohol-free and [MEDICATION NAME] with natural moisturizers, such as Vitamin E and Aloe Vera) to wipe her hands and was not observed performing hand hygiene before delivering the dinner trays to the two residents. The Unit Manager assisted in setting up the dinner trays on residents' over-bed tables then the Unit Manager left their room without performing hand hygiene and only used the Pro-Care wipes to wipe her hands. Review of R18's and R19's current [DIAGNOSES REDACTED]. Further review of R18's current [DIAGNOSES REDACTED].'s and R23's rooms. NA3 wiped her hands with the Pro-Care wipes in between resident rooms and was not observed performing hand hygiene before delivering the dinner trays to the residents' rooms. NA3 assisted in setting up the residents' meals on the residents' over-bed tables in their rooms. Review of R22's current [DIAGNOSES REDACTED]. 4) Observation on 5/5/20 at 5:20pm revealed that NA4 brought dinner trays to R24's, R25's, R26's and R27's rooms. NA4 was wearing gloves and was not observed performing hand hygiene before delivering the dinner trays to the residents' rooms. NA4 assisted in setting up the residents' meals on the residents' over-bed tables in their rooms. In an interview with NA4 on 5/5/20 at 5:29pm when asked if she should have performed hand hygiene in between resident rooms, NA4 stated, I felt like I should have but since they're not on isolation, I didn't do it. Review of the current [DIAGNOSES REDACTED]. Further review of the current [DIAGNOSES REDACTED]. In an interview with the DON on 5/5/20 at 5:36pm, when told about the observations of lapses in hand hygiene by nursing staff while distributing meal trays to some of the residents on first and second floors, the DON stated, (They should do) hand hygiene in between rooms. When asked if the use of the Pro-Care wipes could be a substitute for hand washing or use of hand sanitizer, the DON stated, They should have used the alcohol-based sanitizer. Review of the facility's undated Passing Trays policy and procedure, revealed that it did not address the necessity of performing hand hygiene in between resident rooms when delivering meal trays. Review of the facility's undated Hand Hygiene Guideline revealed, .Appropriate hand hygiene is essential in preventing transmission of infectious agents. Further review of the same policy and procedure revealed under Purpose: To cleanse hands to prevent the spread of potentially deadly infections; To provide a clean and healthy environment for residents, staff and visitors; To reduce the risk to the healthcare provider of colonization or infections acquired from a resident. The Hand Hygiene Guideline further indicated, Hand hygiene continues to be the primary means of preventing the transmission of infection .In addition to the clinical situations when handwashing is indicated, hand hygiene is required in the following situations: Before and after touching a patient .After contact with inanimate surfaces and objects (including medical equipment) in the immediate vicinity of the patient; After removing gloves. The same policy and procedure also stated under Procedure, .Staff must perform hand hygiene even if gloves are utilized .Gloves or the use of baby wipes are not a substitute for hand hygiene.