STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146048	A. BUILDING _____ B. WING _____	09/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TAYLORVILLE SKLD NUR & REHAB	800 MCADAM DR TAYLORVILLE, IL 62568

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** - Many	**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 prevent potential infection and transmission of COVID-19 by failing to ensure adherence to infection control practices to prevent the transmission of Coronavirus (COVID-19) as evidenced by failures to: 1) ensure clean laundry were stored in a sanitary manner that prevent risk of contamination. This failure had the potential to affect all the residents residing in the facility; 2) follow infection control practices related to the use of disinfecting wipes for shared equipment for one (R1) resident. This had the potential to affect the five residents in the West Unit who did not test positive for COVID-19. Findings include: 1. On 9/3/20 at approximately 3:54pm, during the laundry tour with E1, five metal mesh shelving full of clean laundry were observed uncovered with linens exposed. In addition, the bottom mesh shelves were approximately two inches off the floor. The floor within the perimeter of the shelves was dusty, with streaks of dried brown liquid and debris. There were hospital pants, blankets, resident gowns, and towels on the lowest shelves that touched the floor while the rest of the linens were in close proximity to the floor. When asked about the observation, E1 explained, We normally do not cover these (referring to the metal wire mesh shelves) I think we should have. E1 was asked what unit used the linen. E1 responded, We deliver them to all the units. When asked when the floor was last cleaned or swept. E1 verbalized that she was not sure and volunteered to clean the floor afterwards. On 9/3/2 at 4:04pm, a pair of uncovered goggles and a face shield was observed inside the linen cart on top a pile of clean linens on the topmost shelf. The cart was located in the west unit, near the nurse's station. The Licensed Practical Nurse (LPN) 1 who was present during the observation immediately removed the items. The goggles and face shield did not have labels or names nor they were inside any packaging. On 9/3/20 at approximately 4:30pm during the unit tour with the Director of Nursing (DON) in the west unit, the DON was asked about the above-mentioned observations. The DON stated only clean linens should be placed inside the clean linen cart. While talking with the DON, a used face shield was observed hanging on the mobile vital signs monitoring machine near the linen cart. The DON discarded the face shield and verbalized, That should not be in there either. The DON was also informed of the observations in the laundry room. The DON confirmed, The clean linens should have been fully covered and should not touch the floor. The DON added that she expected staff to maintain the cleanliness of the laundry room for infection control purposes. Review of the facility's Handling Linen/Laundry policy number RC8.08 dated 9/15/19 provided by the facility did not include provisions on the proper storage of clean linen in the laundry room and the linen carts on the floors nor it addressed the importance of maintaining cleanliness in the laundry room. There was no additional linen handling and or storage policy provided prior to the survey's exit. Review of an article titled Handling Clean Linen in a Healthcare Environment revealed, .Research shows that outbreaks of infectious diseases associated with laundered health care textiles .Exposure of clean textiles to environmental contamination is most often cited as the cause. Under Storage, it revealed, Adequate storage space for HCTs (healthcare textile) is especially important. Ideally, space is set aside where the linen can be both stored and prepared for distribution, and kept separate from any soiled linen and other possible contaminants. Nothing should be stored in the area except the clean linen. Retrieved on 9/21/20 from https://industryperspectives.com/wp-content/uplo ads/2017/04/hygienic-clean-linen.pdf 2. Observations made in the West Unit at 4:43pm on 9/3/20, noted NA1 going into R1's room to check R1's oxygen saturation level (measure of how much oxygen the blood is carrying) and temperature. After the procedure, NA1 took one Super Sanicloth disinfecting wipe with her bare hands. NA1 had areas of dry and reddened skin on both fingers. NA1 wiped the pulse oximeter for eight seconds and placed it on the table. NA1 proceeded to walk towards R2's room to check R2's oxygen saturation and temperature. When asked what she needed to monitor for the equipment to be properly disinfected, NA1 was unsure. NA1 stated she could check with the nurse. During an interview with the DON on 9/3/20 at 4:53pm, when asked about her expectation from staff when disinfecting shared equipment, the DON stated, That they (staff) disinfect the equipment before checking somebody else. Disinfect it using Caviwipes or the Super Sanicloth (disinfectant wipes). Review of facility's policy titled Cleaning Contaminated Equipment dated 9/3/2020 revealed under procedures, 1. Once staff uses equipment on a resident it will be properly sanitized prior to use on another resident unless they have their own designated equipment. 2. The process of cleaning equipment will be follows .B. The staff will clean item according to manufactures guidelines on contact time. Ensure the equipment remains visibly wet for the entire duration of contact time. Review of Super Sani-Cloth wipe label revealed, To disinfect and deodorize: To disinfect non-food contact surfaces only: Unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for two (2) minutes. Let air dry . According to CDC article titled Preparing for COVID-19 in Nursing Homes updated June 25, 2020 under Environmental Cleaning and Disinfection revealed, Ensure EPA-registered, hospital grade disinfectants are available to allow for frequent cleaning high-touch surfaces and shared resident care equipment. Use an EPA-registered disinfectant from List N on the EPA website to disinfect surfaces that might be contaminated with [DIAGNOSES REDACTED]-CoV-2. Ensure HCP are appropriately trained on its use. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html According to CDC article titled Cleaning and Disinfecting Your Facility updated July 28, 2020 revealed, Wear disposable gloves to clean and disinfect. Under Disinfect revealed, Follow the instruction on the label to ensure safe and effective use of the product .Keeping surface wet for a period of time (see product label). Precautions such as wearing gloves and making sure you have good ventilation during use of the product. https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html According to EPA (United States Environmental Protection Agency) article titled List N: Disinfectants for Use Against [DIAGNOSES REDACTED]-CoV-2-(COVID-19) updated September 17, 2020 under Follow the Label revealed, When using an EPA-registered disinfectant, follow the label directions for safe, effective use. Make sure to follow the contact time, which is the amount of time the surface should be visibly wet . https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-[DIAGNOSES REDACTED]-cov-2-covid-19.
F 0882 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to designate an individual as Infection Preventionist who is responsible for the facility's Infection Prevention and Control Program (IPCP), has completed specialized training organized by the state or recognized professional societies, that participates in the quality assessment and assurance committee, and report to the committee on the IPCP on a regular basis. This failure has the potential to affect all 52 residents that resided in the facility at the time of survey. Findings include: On 9/3/20 at approximately 4:30pm, the Administrator indicated The Director of Nursing (DON) has just started three weeks ago and has confirmed that the DON was the facility's designated Infection Preventionist. Review of the DON's training record on Infection Control Preventionist training, the untitled document indicated 23 Modules were completed, however, the name of the DON was handwritten on the document. During the joint interview of the Administrator, DON, and Senior DON on 9/14/20 at 2pm, when asked, the DON stated I have a difficulty printing my certificate from my other job. Further, the Administrator stated, Our Senior DON also is an Infection Preventionist. She works under me and goes to our other facilities. She is in our building for eight

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 0882 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) hours a day two times a month. Review of the facility's QAPI attendance record indicated meetings were held on 9/26/2019, 3/19/20, 4/23/20, and 7/16/20. Further review of the same record revealed that the Senior DON attended the meeting on 7/16/20 via phone. Review of the DON's Nursing Home Infection Preventionist Training Course via email correspondence dated 9/16/20 at 12:47pm, the DON completed the course on 9/16/20. Based on the QSO 20-03-NH dated November 22, 2019 revealed .B Infection Preventionist Assessments Comments B.1. The facility has designated one or more individuals with initial and maintain ongoing specialized training in infection prevention and control as the Infection Preventionist (IP). This individual works at least part-time in the facility. Examples of specialized training may include: Participation in infection control courses organized by the state or recognized professional societies (e.g., APIC, SHEA, state/local healthdepartment, CDC). A free online and on demand infection prevention and control training titled Nursing Home Infection Preventionist Training Course is available on CDC's TRAIN website (https://www.train.org/cdctrain/training_plan/3814) .Yes .No B.2. There is written evidence that the IP is a member of the facility's quality assessment and assurance committee and reports to the committee on a regular basis. https://www.cms.gov/files/document/qso-20-03-nh Review of the the CDC guidelines Preparing for COVID-19 in Nursing Homes updated on June 25, 2020 revealed Facilities should assign at least one individual with training in IPC (Infection Prevention and Control) to provide on-site management of their COVID-19 prevention and response activities because of the breadth of activities for which an IPC program is responsible, including developing IPC policies and procedures, performing infection surveillance, providing competency-based training of HCP, and auditing adherence to recommended IPC practices . Core Practices .These practices should remain in place even as nursing homes resume normal activities . Assign One or More Individuals with Training in Infection Control to Provide On-Site Management of the IPC Program. This should be a full-time role for at least one person in facilities that have more than 100 residents or that provide on-site ventilator or [MEDICAL TREATMENT] services. Smaller facilities should consider staffing the IPC program based on the resident population and facility service needs identified in the facility risk assessment . https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html