STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145631	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEWMAN REHAB & HEALTH CARE CTR	418 SOUTH MEMORIAL PARK DRIVE NEWMAN, IL 61942

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 the unprecedented Coronavirus global pandemic that resulted in the Presidential Declaration of a State of National Emergency dated 3/13/20, the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Memo QSO-20-14-NH revised on 3/13/20, Nursing Home guidance from the Centers for Disease Control and Prevention (CDC), observation, interview and record review, the facility failed to ensure adherence to infection control practices to prevent the transmission of the Coronavirus (COVID-19) as evidenced by failure to perform hand hygiene and glove use; and proper handling of clean linen. This had the potential to affect the 39 residents in the facility. Findings include: 1. A. On 6/10/20 at 11:19am, Nursing Assistant1 (NA1) was observed going inside room [ROOM NUMBER] to check R1's blood pressure in the North Hall. NA1 used an Equate wrist blood pressure monitor. After the procedure, NA1 exited the room wearing the same gloves and proceeded to grab the tub of Clorox disinfecting wipes. NA1 took one wipe and disinfected the blood pressure cuff. NA1 did not perform hand hygiene prior to disinfection. B. On 6/10/20 at 11:27am, NA1 was observed going inside room [ROOM NUMBER] to check R2's blood pressure. NA1 used the Omron upper arm blood pressure monitor. After the procedure, NA1 exited the room wearing the same gloves and proceeded to grab the tub of Clorox disinfecting wipes. NA1 took one wipe and disinfected the blood pressure cuff. NA1 did not perform hand hygiene prior to disinfection. When asked what she missed, NA1 stated that since the blood pressure cuff was already contaminated she did not have to change her gloves and do hand hygiene before the disinfection of equipment. During a phone interview with Licensed Practical Nurse1/MDS Coordinator (LPN1) on 6/22/20 at 9:19am, when asked if after checking blood pressures, she expected staff to change gloves and perform hand hygiene before they cleaned and disinfected the blood pressure cuff, LPN1 stated, Yes. C. On 6/10/20 at 12:20pm, Dietary Manager (E1) was observed passing lunch trays in the West Hall. E1 entered R3's room and placed the lunch tray on R3's table. E1 failed to perform hand hygiene after exiting R3's room. E1 proceeded to pick up R4's lunch tray from the food cart. E1 entered R4's room and placed the lunch tray on R4's table. E1 failed to perform hand hygiene after exiting R4's room. At 12:22pm, E1 picked up R5's lunch tray from the food cart and entered R5's room. E1 failed to perform hand hygiene after exiting R5's room. At 12:23pm, E1 picked up R6's lunch tray from the food cart and entered R6's room. E1 did not perform hand hygiene when he exited R6's room. When asked when he should perform hand hygiene, E1 stated he would do hand hygiene only when he touched something in the resident's room. During a phone interview with LPN1 on 6/22/20 at 9:19am, when asked about her expectation when staff brought food trays inside the rooms, LPN1 stated, They should have clean hands and gloves, take the food in and take off the gloves and wash their hands. D. On 6/10/20 at 12:30pm, E2 entered R7's room and placed the clean clothes and took the empty hangers from R7's closet. E2 exited the room and placed the hangers in the hanger rack on top of the clean linen cart. E2 failed to perform hand hygiene as she exited R7's room. E2 entered R5's room and brought R5's clean clothes. E2 took the empty hangers from R5's closet. E2 failed to perform hand hygiene as she exited R5's room. At 12:31pm, E2 entered R6's room and placed R6's clean clothes inside the closet. When asked when she should perform hand hygiene, E2 stated, I usually wait until I'm done with everything. During interview with Housekeeping and Laundry Supervisor (E3) on 6/10/20 at 1:40pm, when asked what staff should do when delivering clean linen to residents' rooms, E3 stated, Everything needs to be covered, we announce who we are. We bring clean clothes to the closet. Take out empty hangers. Close the closet. She stated that laundry staff should use the hand sanitizer after leaving every room. She further stated, Patient's could have touched anything in the room, or may have coughed on it or maybe patient didn't even wash their hands. When asked if laundry staff do carry bottle of hand sanitizer, E3 stated, They should have. During a phone interview with LPN1 on 6/22/20 at 9:19am, when asked what she expected staff to do when they bring clean clothes inside residents' rooms and takes out empty hangers in their closets, LPN1 stated, Well, I would expect them to remove their gloves and wash their hands. Review of facility's policy titled Hand Hygiene dated 12/7/18 revealed, All staff will wash hands, as washing hands as promptly and thoroughly as possible after resident contact and after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them is an important component of the infection control and isolation precautions. Review of facility's policy titled Cleaning of Non-Critical Resident Care Items dated 12/7/18 revealed, Non critical equipment is defined as equipment that touches intact skin .Examples of non-critical items include, but are not limited to the following: crutches, walkers, canes, bedside tables, blood pressure cuffs, stethoscope . Under Procedure, it revealed, 3. Apply clean disposable gloves prior to washing/disinfecting resident care equipment. In a CDC article titled Hand Hygiene Guidance dated Jan. 30, 2020 revealed, The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications .after touching a patient or patient's immediate environment, after contact with blood, body fluids, or contaminated surfaces, immediately after glove removal. https://www.cdc.gov/handhygiene/providers/guideline.html 2. On 6/10/20 at 12:29pm, laundry staff (E2) was observed taking out a clean blanket from the clean laundry bin and held it close to her body, touching her scrub top. E2 handed the blanket to an unnamed staff standing outside of R8's room. During interview with E3 on 6/10/20 at 1:40pm, when asked how staff should carry clean linen, E3 stated, Hold it away from your body. During interview with LPN1 on 6/22/20 at 9:19am, when asked about her expectation from staff when handling clean clothes of residents, LPN1 stated, Not close to the body. Review of facility's policy titled Laundry/Linen Handling dated 12/7/18 did not reveal documentation on handling of clean linen. In an article by McKnight's Long-Term Care News titled Laundry/Housekeeping Feature: No dirty Laundry dated Aug. 7, 2006 revealed, Experts agree that the most common gaps in practice relate to linen collection and containment .Staff should be taught how to contain linen safely and to hold linen away from their uniforms when collecting and handling it . https://www.mcknights.com/news/laundry-housekeeping-feature-no-dirty-laundry/ In a CDC article titled Appendix D - Linen and laundry management dated March 27, 2020 under Best practices for management of clean linen revealed, Sort, package, transport and store clean linens in a manner that prevents risk of contamination by dust, debris, soiled linens or other soiled items. https://www.cdc.gov/hai/prevent/resource-limited/laundry.html

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.