STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145640	A. BUILDING _____ B. WING _____	03/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHURCH CREEK	1200 WEST CENTRAL ROAD ARLINGTON HTS, IL 60005

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: (1) perform hand hygiene when appropriate during incontinence care for two (R1 and R2) of two residents observed during incontinence care; (2) ensure that blood pressure (BP) cuff and pulse oximeter shared among residents were properly cleaned and disinfected after each resident use for three residents (R3, R4 and R5); (3) appropriately use personal protective equipment (PPE) when delivering clean linen for one (R2) of one resident on droplet and contact isolation; (4) ensure clean linen was handled to prevent contamination; and, (5) perform hand hygiene when delivering room trays for two (R6 and R7) of two residents in the sample of 7. Findings include: 1.A. Review of R1's current care plan revealed under Focus, RESPIRATORY INFECTION: I have an actual impairment with my immunity system secondary to development of an INFECTION: [MEDICAL CONDITION] (an infectious disease usually caused by [DIAGNOSES REDACTED] bacteria which generally affects the lungs) and Aspiration Pneumonia, +MRSA ([MEDICAL CONDITION]-Resistant Staphylococcus Aureus - bacterium that causes infections in different parts of the body which is tougher to treat than most strains of staphylococcus aureus because it is resistant to some commonly used antibiotics) requiring strict isolation. Review of a document titled, Resident on Isolation & Pneumonia dated March 2020 revealed that R1 was on contact precautions. Further review of the same document revealed under S & S (signs and symptoms), Productive cough and under Comments, indicated, .Resident on TB ([MEDICAL CONDITION]) medicines (R1's TB medications were extended to nine months due to previous history of non-compliance while he was in another facility but R1 had tested negative for TB). In an observation on 3/25/20 at 3:49pm, Nursing Assistant (NA1) washed his hands in the staff wash room and donned an isolation gown (a gown intended to protect healthcare patients and personnel from the transfer of microorganisms, body fluids, and particulate material), gloves and N95 mask (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) before entering R1's room and starting R1's personal care. NA1 donned the isolation gown by pulling the gown over his head (this manner of putting on the isolation gown increases the possibility of contamination). NA1 started cleansing R1's perineal area using cleansing wipes. After removing gloves, NA1 washed his hands for five seconds and donned a new pair of gloves. NA1 removed the urine saturated incontinence brief then went to R1's wash room to get and donned a new pair of gloves without performing hand hygiene. NA1 wiped R1's rectum, removed his gloves and went back to the wash room to get a new pair of gloves. Without performing hand hygiene, NA1 donned a new pair of gloves and put the clean incontinence brief on R1. NA1 removed his gloves and donned a new pair of gloves without hand hygiene before emptying the trash to put the garbage in the isolation garbage bin. NA1 then washed his hands for 10 seconds after removing his gloves. NA1 doffed his isolation gown and left the room after washing his hands for 10 seconds. In an interview with NA1 on 3/25/20 at 4:05pm, when asked how was he supposed to don the isolation gown, NA1 stated, Tie it first then I put it over my head then close (sic) behind. When asked if that was the proper way to don an isolation gown, NA1 stated, My shoulders hurt, I should have talked to (the) supervisor. They could have looked for someone else to do it. When asked how long he should have washed his hands, NA1 stated, 20 seconds. NA1 further stated, He (R1) was not soiled. If he was soiled, I would have done it for 20 seconds. He was clean, so it's okay not to wash for 20 seconds. In an interview with the Director of Nursing (DON) on 3/25/20 at 4:27pm when told about how NA1 don the isolation gown due to shoulder pain, the DON stated, (He should have) asked for assistance from other staff. When told about the length of time NA1 washed his hands and NA1's failure to perform hand hygiene in between gloving, the DON stated, (NA1 should have) washed his hands for 20 seconds and washed his hands every time he changed gloves. Review of the facility's Personal Protective Equipment Techniques policy and procedure with the last revision date of 10/15/14 revealed under Gown Technique - Putting Gown On, 1. Grasp gown by shoulder seams; 2. Open gown and slip hands through sleeves; 3. Tie neck strings and waist ties. Review of the facility's Hand Washing policy and procedure with the last revision date of 1/17/16 revealed under Fundamental Information, .The use of gloves DOES NOT eliminate the need to wash hands . Further review of the same policy and procedure revealed under Procedure - Hand washing is performed: .c. Before and after each resident contact; d. Wash hands if moving from a contaminated body site to a clean body site during resident care; e. After contact with soiled or contaminated articles, such as articles that are contaminated with blood or body fluids; f. After contact with an object .or source where there is a concentration of microorganisms such as mucous membranes, non-intact skin, body fluids, or wounds .l. Before applying and after removal of medical/surgical or utility gloves . The facility's Hand Washing policy and procedure also indicated under Method/Steps: .Rub hands together using friction for 20 (CDC (Centers for Disease Control and Prevention) guidelines) seconds . B. Review of R2's current care plan revealed under Focus, I have a Respiratory Infection requiring droplet/respiratory isolation due to (+) HUMAN METAPNEUMOVIRUS (HMPV) (a leading cause of acute respiratory infection, particularly in children, immunocompromised patients, and the elderly). Review of a document titled, Resident on Isolation & Pneumonia dated March 2020 revealed that R2 was on droplet and contact precautions. Further review of the same document revealed under S & S (signs and symptoms), Productive cough. In an observation on 3/26/20 at 11:24am, NA2 and the Physical Therapy Assistant (PTA) washed their hands and donned isolation gowns, N95 masks and gloves before starting R2's personal care. The PTA was asked to help with positioning as NA2 performed R2's perineal care. The PTA removed R2's shoes with her gloved hands. Without changing her gloves, the PTA touched the handrail on the left side of R2's bed and moved R2's water cup from the over-bed table to the dresser. Still wearing the same pair of gloves, the PTA placed the gait belt in R2's drawer, went to the right side of R2's bed and fixed R2's blouse. The PTA also helped remove the soiled incontinence brief from R2 while NA2 was providing the incontinence care. The PTA continuously assisted with R2's repositioning throughout the procedure without changing her gloves. When NA2 was done with R2's incontinence care, the PTA fixed R2's pillow and assisted in putting the sheet and blanket over R2. After helping NA2, the PTA removed her gloves and isolation gown then performed hand hygiene before leaving R2's room. In an interview with the DON and the Assistant Director of Nursing (ADON) on 3/26/20 at 1:30pm when told about the above observation, the DON stated, If she (PTA) touched something dirty, she should have washed her hands. The ADON added, Especially that the resident is on droplet precautions, the shoes were probably contaminated. Review of the facility's Personal Protective Equipment policy and procedure, with the last revision on 10/15/14, indicated under Procedure, All employees using PPE are expected to observe the following precautions: .2. Remove PPE after it becomes contaminated .4 .Replace gloves if .contaminated . 2. Observation of Licensed Practical Nurse (LPN1), on 3/26/20 at 3:25pm, revealed LPN1 came out of R3's room with the vital signs (VS) machine then went to R4's room with the VS machine. There was no container of sanitizing wipes observed in the VS machine. In an interview with R3 on 3/26/20 at 3:32pm, R3 stated that the nurse (LPN1) just checked her vital signs including her blood pressure and pulse rate and oxygen saturation using the pulse oximeter. On 3/26/20 at 3:33pm, LPN1 was observed coming out of R4's room with the VS machine and instructed NA1 to check R5's vital signs. R5 was in the hallway at that time. LPN1 took R5 from the hallway to the shower room so NA1 could check R5's vital signs. In an interview with LPN1 on 3/26/20 at 3:42pm, LPN1 verified that she checked R3's and R4's oxygen saturation, pulse rate, temperature and blood pressure in their rooms as part of her charting and evaluation every shift. LPN1 also verified that she instructed NA1 to get the same set of

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145640	A. BUILDING _____ B. WING _____	**03/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHURCH CREEK	**1200 WEST CENTRAL ROAD ARLINGTON HTS, IL 60005**

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	(continued... from page 1) vital signs for R5. When asked if the blood pressure cuff and pulse oximeter were sanitized between resident use, LPN1 verified that she did not sanitize them as the sanitizing wipes were in the medication cart. In an interview with the DON on 3/26/20 at approximately 4pm when told about the observation of nursing staff checking VS without sanitizing the medical equipment between resident use, the DON stated, They (nursing staff) should sanitize (the medical equipment) using the sanitizing wipes between residents. Review of the facility's Cleaning & Disinfection of Nursing Equipment policy and procedure with an effectivity date of 6/1/18 revealed under General Information, Equipment and surfaces are cleansed and disinfected with an EPA (Environmental Protection Agency)-registered and approved disinfectant according to a specified frequency/schedule. In addition, equipment and surfaces are cleansed as needed to be free of soil and contamination with infectious substances. Further review of the same policy and procedure revealed under Procedures, Nursing responsibility include cleaning and disinfecting equipment between patient uses . The same policy and procedure indicated under 5. Blood Pressure Cuffs/stethoscopes: a. Cuffs and stethoscopes are cleansed between resident uses with approved disinfectant solution .i. Housekeeping is responsible for wall cuffs and sphygmomanometer (an instrument for measuring blood pressure); Nursing is responsible for portable units; 6. Pulse Oximeter & Probe: a. Oximeter .Clean and disinfect all surfaces with approved disinfectant solution .Oximeters are cleansed by Nursing Service personnel as assigned on a weekly basis, when they are soiled/contaminated, and as needed . 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 . 3. Review of R2's current care plan revealed under Focus, I have a Respiratory Infection requiring droplet/respiratory isolation due to (+) HUMAN METAPNEUMOVIRUS (HMPV). Review of a document titled, Resident on Isolation & Pneumonia dated March 2020 revealed that R2 was on droplet and contact precautions. Further review of the same document revealed under S & S (signs and symptoms), Productive cough. Observation of a laundry staff (E1) on 3/25/20 at 10:32am revealed that E1 was delivering clean linen to R2's room. E1 was delivering the clean linen using a cart that was not covered. Further observation revealed that E1 donned an isolation gown before entering R2's room. Another staff member told him to ask the nurse for an N95 mask. E1 went towards the nurses station wearing the isolation gown but came back without an N95 mask. E1 entered R2's room without wearing an N95 mask and gloves. E1 hung R2's clothes in R2's closet. R2 was in the room at that time. E1 doffed the isolation gown by pulling the gown over his head (this manner of removing the isolation gown increases the possibility of contamination), left R2's room without performing hand hygiene and went to the soiled utility room. In an interview with E1 on 3/26/20 at 10:26am when asked if he should have donned gloves and mask when he entered R2's room, E1 stated, I couldn't find gloves and mask. I couldn't find the nurse. When asked if he washed his hands before delivering the clean linens to R2's room, E1 stated, Before I came up, I washed my hands. I should have washed my hands before leaving the room so we don't spread serious contamination, (we) should be twice as careful because of the [MEDICAL CONDITION]. In an interview with the DON and ADON on 3/26/20 at 1:30pm, when asked of their expectations of laundry staff when delivering clean linens to residents' room on isolation, the DON stated, (They should wear) gown, mask, gloves, wash hands especially on an isolation room just like what the (nursing) aides do. The ADON stated, Or (he could) ask the aide to put the clothes there if there's an aide inside so as not to waste more PPE. When asked what if there was no nursing aide in the room, the ADON stated, Then he has to don the needed PPE especially that she's (R2) on droplet precautions. During the same interview with the DON and ADON, when asked if it was acceptable that E1 did not wash his hands prior to entering R2's room as he stated that he washed his hands downstairs in the laundry room before going up, the DON stated, (That is) not acceptable. The ADON added, He had touched a lot of surfaces for sure before he got on the floor, like the elevator button. When told that E1 stated there were no gloves and mask available that was why he entered R2's room with just the isolation gown on, the DON stated, (The) extra N95 masks are with the nurses because I leave some for the PM (evening) shift and I have some. The ADON also stated, He probably looked in the wrong drawer that's why he couldn't find the gloves. In an interview with the Administrator, DON and ADON on 3/26/20 at 4:22pm, when asked how clean linens should be transported, the ADON stated, (They) should be covered. Review of the facility's Housekeeping and Laundry Department training and operations manual dated January 2019 revealed under Handling Clean Linens, .h. Use a clean draw sheet to cover cart when delivering clean linen to the patient rooms. Dispose of (sic) draw sheet into the soiled linen hamper when finished. Review of the facility's Transmission Precautions: Droplet policy and procedure with the last revision on 10/15/14 revealed under Procedure, .Wash hands .before leaving the resident's room . Review of the facility's Transmission Precautions: Contact policy and procedure with the last revision on 10/15/14 revealed under Procedure, .Wear clean, non-sterile gloves when entering the room .before leaving the room .wash hands immediately with an antimicrobial agent .Do this to avoid transfer of microorganisms to other residents or environments .Wear a mask if you anticipate exposure to secretions or potential airborne pathogens . 4. Observation on 3/26/20 at 3:25pm revealed NA1 was in the hallway handling linens and was holding them against his uniform. In an interview with the Administrator, DON and ADON on 3/26/20 at 4:22pm, the Administrator stated, They (staff) should carry linen away from the body. Review of the facility's Housekeeping and Laundry Department training and operations manual dated January 2019 revealed under Storage, Collection and Transportation of Linens, .Clean linen is handled and stored in such a way as to minimize contamination from contact or airborne means . Further review of the same policy revealed under Handling Clean Linens, .c. Handle linen as little as possible . 5. Observation on 3/25/20 at 12:10pm revealed that a concierge (E2) brought a lunch tray to R7's room and a nursing assistant (NA3) brought a lunch tray to R6's room. Both E2 and NA3 were not observed performing hand hygiene before delivering the lunch trays to R7 and R6. Review of R6's and R7's current care plans revealed under Focus, .at risk for infection related to COVID-19 pandemic infection. Further review of their care plans revealed under Interventions, .Meticulous hand hygiene before and after each encounter with resident and others . E2 assisted in setting up the lunch tray on R7's over-bed table then E2 left R7's room without performing hand hygiene. NA3 was observed helping R6 position the over-bed table and setting the tray on top of the over-bed table. NA3 left R6's room without performing hand hygiene. In an interview with NA3 on 3/26/20 at 10:45am, NA3 stated, I didn't wash my hands because I just delivered the tray. In an interview with the DON and the ADON, when told about the observations of lapses in hand hygiene by nursing and ancillary staff while delivering meal trays to residents' rooms, the DON stated, They should wash their hands before getting the tray from the kitchen and after delivering the tray. The ADON added, I would just do it in the resident's bathroom before leaving the room because you would have touched different surfaces in the resident's room like the door knob. Review of the Meal Service/Delivery and Guest Trays policy and procedure with an effectivity date of 9/1/18 revealed that it did not address hand hygiene when staff were delivering meal trays to resident rooms.