STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145798	A. BUILDING _____ B. WING _____	**03/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRYSIDE NURSING & REHAB CTR	**1635 EAST 154TH STREET DOLTON, IL 60419**

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 the Centers for Disease Control and Prevention (CDC) guidelines, and failed to follow the manufacturer's guidelines for disinfection of glucometers following blood glucose sampling for one resident (R01) of two residents sampled for blood glucose monitoring. The facility also failed to maintain proper hand hygiene and glove changes following incontinence care for one resident (R02) of one resident sampled for incontinence care. Findings include: 1. R01's current electronic Face Sheet lacked a [DIAGNOSES REDACTED]. The Sani Cloth Bleach wipe container indicated on the label a four minute contact time was required to be effective. RN1 placed the glucometer, one box of gloves and the card board box directly on R01's dresser and did not use a barrier between the supplies and the dresser. RN1 used the glucometer to check R01's blood sugar by obtaining blood from R01's finger placed in contact with the small strip on the glucometer. RN1 exited R01's room and placed the glucometer and other supplies directly on the treatment cart and did not use a barrier between the dirty supplies and the treatment cart. RN1 then washed her hands and went to the computer where she began to work. RN1 did not sanitize the glucometer after using it on R01. During an interview on 3/25/20 at 3:15pm, RN1 indicated R01 was not a diabetic and the physician did not order glucose monitoring for the resident. RN1 indicated her supervisor told her to demonstrate glucose monitoring, but she had already completed glucose monitoring for her residents. She decided to check a glucose level on R01 because he was standing at the nursing station. She did not know a barrier between clean supplies and resident furniture was required and did not know the glucometer needed to be in contact with the Sani Cloth wipes for four minutes. She said she forgot to clean the glucometer after use on R01 and indicated the same glucometer would be used on other residents later in the day. During an interview on 3/25/20 at 3:30pm, the Assistant Director of Nursing (ADON) reported she wondered why RN1 was doing a glucose monitoring check on R01 who was not diabetic. She indicated RN1 should not have performed glucose monitoring on a resident that did not have a physician's orders [REDACTED]. The DON stated that the glucometer was used on multiple residents and was always supposed to be cleaned following the manufacturer's instructions on the Sani Cloth Bleach wipe container to ensure the glucometer was cleaned and sanitized properly between resident's use. A review of the Sani Cloth Bleach Germicidal Disposable Wipe Technical Data Bulletin with a date of last revision 8/12/16, indicated a required a disinfection contact time of four minutes to be effective. A review of the Centers for Disease Control and Prevention (CDC) website, at www.cdc.gov, section titled, Infection Prevention During Blood Glucose Monitoring and Insulin Administration, indicated that if the glucose meters must be shared, the device should be cleaned and disinfected after every use per the manufacturer's instructions. 2. R02's current electronic Face Sheet indicated a [DIAGNOSES REDACTED]. The quarterly MDS dated [DATE] indicated R02 had moderately impaired cognition, required extensive assistance of two staff for toilet use and was frequently incontinent of bowel and bladder. The comprehensive care plan last revised 1/18/20 listed a problem for antibiotic therapy related to R02 having a history of urinary tract infection dated 8/31/19. The care plan directed staff to keep R02's perineal area clean and dry, monitor for signs of infection and administer antibiotics as ordered. During an observation and interview on 3/25/20 at 1:00pm, Nursing Aide (NA1) sanitized her hands, donned gloves and cleaned urine from R02's perineal area. NA1 touched a clean bed pad and bed sheets with the same dirty gloves then wrapped the dirty urine soaked bed pad in a clean gown and carried it out into the hall to the dirty laundry barrel while touching the door handle. NA1 returned to R02's room, removed her gloves but did not sanitize her hands. She touched her hair and uniform shirt then touched R02's bedside table. Prior to exiting R02's room, NA1 placed her hand down into the open and broken soap dispenser in R02's room to obtain some soap to wash her hands. NA1 stated she forgot to get a bag to contain the soiled bed pad so she wrapped it in the gown and carried it into the hall not bagged. She said she forgot to wash her hands and knew she touched surfaces with her dirty hands. She did not know how long the soap dispenser had been broken, but staff have had to place their hands down into the soap in the dispenser to obtain the soap for a few days. During an interview on 3/25/20 at 3:30pm, the Assistant Director of Nursing (ADON) stated staff needed to perform hand hygiene to sanitize after providing perineal care and prior to touching anything else in order to decrease the spread of any infection. The facility provided a policy entitled Perineal Care with a revised date of August 2008 which directed staff to perform perineal care then remove gloves, discard them into the designated container and wash and dry hands thoroughly.

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.