STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145689	A. BUILDING _____ B. WING _____	**07/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE OF ELK GROVE VILLAGE	**1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007**

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.** Based on observation, interview, and record review, the facility failed to follow standards of infection control practices with regards to hand washing, donning and doffing of personal protective equipment (PPE). This applies to 5 of 6 residents (R1, R2, R3, R4, R6) reviewed for infection control practices. The findings include: 1. On 7/27/20 at 10:34am, V9 (Nurse) entered R1's room wearing only N95 mask. V9 failed to wear gloves, gowns or face shield before entering R1's room. V9 came out of R1's room failed to perform hand hygiene and was walking away before been stopped. V9 was also observed with a brown paper bag that contained an isolation gown. On 7/27/20 at 10:35am, V9 stated R1 is on airborne/contact isolation and she was expected to wear the gown and gloves in addition to the N95 mask she was wearing. V9 further stated staff are supposed to have their gowns in the brown bags they are carrying around but did not put it on because she went in to talk to R1 and not provide care. Review of R1's record showed R1 was readmitted to the facility 7/22/20 and was placed on airborne and contact isolation precautions. 2. On 7/27/20 at 10:40am, V11 (Certified Nursing Assistant, CNA) was coming out of R2's room. V11 had removed her gloves in R2's room. V11 failed to perform hand hygiene. V11 then stood at R2's door to remove the disposable isolation gown she was wearing. At this point, V11 realized R1's call light was on, V11 entered R1's room and closed the door. Few minutes later, V11 came out of R1's room, removed her disposable isolation gown and rolled it into the brown paper bag that was placed on the floor by R2's door. V11 failed to perform hand hygiene again after removing her gloves. V11 used the same hands to open R6's door before she was interrupted. Review of facility's isolation list showed R2 and R6 were both listed as being on airborne and contact precautions. 3. On 7/27/20 at 11:17am, V12 (Admission Manager) was coming out of R4's room. V12 was seen removing her disposable isolation gown and placing it in the brown paper gown she was carrying with her. When prompted, V12 stated she intended to dispose of the gown in her office and get a new gown. On 7/27/20 at 11:30am, V3 (Infection Control Nurse/ADON) stated staff are required to wear N95 mask, face shield or goggles, gloves and gown prior to entering airborne/contact isolation rooms. V3 stated new residents are placed on airborne/contact precautions. V3 stated staff are expected to perform hand hygiene when gloves are removed. Review of Facility's policy titled, Hand hygiene dated 5/2013, showed . some situations that require hand hygiene include: . before and after entering isolation precaution settings, before applying gloves, after removing gloves . Review of Facility's policy titled, Personal Protective Equipment, dated 5/2013 showed .When removing disposable gown: Remove gown by turning inside out, folding outside or contaminated surface in and rolling upon self. Discard gown in a plastic lined trash can at site of use. Do not reuse disposable gowns. 4. On 7/27/20 at 10:38 AM, V7 (physical therapy staff) prepared to enter the room of R3. V7 placed a brown paper bag on the floor at the entryway and then took a used, balled up, gown out of the bag with her bare hands. After unwrapping the gown and placing it on her body, V7 took a pair gloves from box sitting on top of isolation cart and put them on without hand hygiene. V7 then entered R3's room, went to the bedside of R3, asked R3 how she was doing and came back to the open door and closed it. V4 (nurse manager) and V2 (Director of Nursing) both stated V7 should have performed hand hygiene prior to placing on gloves. .

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE