STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145792	A. BUILDING _____ B. WING _____	03/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WOODBRIDGE NURSING PAVILION	**2242 NORTH KEDZIE CHICAGO, IL 60647**

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, interviews and record reviews, the facility failed to ensure adherence to infection control practices as evidenced by: failure to perform hand hygiene and utilize gloves properly; failure to disinfect shared medical equipment after use for three residents (R7, R14, R18); failure to observe proper handling of clean linens for two residents (R9, R15); failure to follow proper infection control practices related to storage of respiratory supplies for two residents (R8, R16); failure to disinfect high-contact environmental surfaces for two residents (R1, R5); failure to properly store urinals for two residents (R2, R3); and failure to properly dispose used intravenous supplies for one resident (R6). Findings include: 1. A. On 3/25/20 at 10:38am, Laundry Staff1 (L1) was observed briefly washing her hands with soap and water for 14 seconds. L1 was noted to have long fingernails with yellow nail polish. On 3/25/20 at 10:40am, L2 was observed briefly washing her hands with soap and water for 11 seconds. When asked how long they should wash their hands, L1 and L2 were unsure. B. On 3/25/20 at 3:30pm, Nursing Assistant (NA4) was observed briefly washing her hands with soap and water for 10 seconds. When asked how long she should wash her hands, NA4 stated, 15 seconds. C. On 3/25/20 at 3:54pm, Licensed Practical Nurse (LPN3) was observed briefly washing his hands with soap and water for 9 seconds before assisting NA5 in transferring R1 back to bed. After care, LPN3 removed his gloves and washed his hands with soap and water for 15 seconds. When asked how long he should wash his hands, LPN3 stated, 10-20 seconds. During interview with the Director of Nursing (DON) on 3/26/20 at 11:36am, when asked about her expectation from staff on handwashing and hand hygiene, the DON stated that staff should do it for at least 20 seconds. When asked about the policy on the length of fingernails, the DON stated, Nails should be clean and (one-fourth) inch long for all staff. Review of facility's Handwashing/Hand Hygiene policy with revision date of 1/17 revealed, This facility considers hand hygiene the primary means to prevent the spread of infection .#5. Employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water . Review of facility's Nail Hygiene policy dated 5/16/11 revealed, To help prevent the spread of germs and nail infections: keep nails short and trim them often. In a CDC article titled, When and How to Wash Your Hands, dated 10/3/19 revealed, Clean hands can stop germs from spreading from one person to another and throughout an entire community .Scrub your hands for at least 20 seconds. Need a timer? Hum the Happy Birthday song from beginning to end twice. https://www.cdc.gov/handwashing/when-how-handwashing.html In a CDC article titled Nail Hygiene, with review date of 7/26/16 revealed, Appropriate hand hygiene includes diligently cleaning and trimming fingernails, which may harbor dirt and germs and can contribute to the spread of some infections, such as [MEDICATION NAME]. Fingernails should be kept short, and the undersides should be cleaned frequently with soap and water. Because of their length, longer fingernails can harbor more dirt and bacteria than short nails, thus potentially contributing to the spread of infection. https://www.cdc.gov/healthywater/hygiene/hand/nail_hygiene.html 2. A. On 3/25/20 at 3:27pm, NA3 was observed when she entered R4's room. NA3 put a pair of gloves and checked R4's undergarment. R4's undergarment was soiled with urine. NA3 removed her gloves. NA3 did not perform hand hygiene. NA3 left R4's room and went to the nurses' station to get a clean brief. NA3 then went to the linen cart parked in the long unit and looked for a towel. NA3 proceeded to the linen cart parked in the short unit and took a towel. NA3 went back to R4's room and put on new gloves. NA3 did not perform hand hygiene. NA3 removed the soiled undergarment and disposed it in the trash can. With the same gloves, NA3 got a new towel and cleaned R4. NA3 assisted R4 with a new brief and pants. NA3 removed the wet linen on the R4's wheelchair. Still wearing the same gloves, NA3 went to R4's drawer and looked for socks. NA3 assisted R4 with her socks. NA3 used the gait belt around her waist and helped R4 transfer to the wheelchair. When asked what she missed during care, NA3 stated, I should have removed my gloves after I took off the dirty pull-ups and washed my hands. B. On 3/25/20 at 3:54pm, R1 was observed sitting on his recliner. NA5 was observed putting on a pair of gloves and took R1 back to his room. Still wearing the same gloves, NA5 went out of the room to get the hoyer lift. NA5 did not perform hand hygiene before leaving the room and before transferring R1 back to bed, with the assistance of LPN3. NA5 removed her gloves. NA5 did not perform hand hygiene. NA5 put on a new pair of gloves and removed R1's dirty pants and undergarment soiled with stool. NA5 placed the soiled undergarment in the trash can and placed the dirty pants on R1's bedside table. Without changing her gloves, NA5 wiped R1's periarea and buttocks. NA5 placed the soiled towel and soiled underpad on top of R1's bedside table. NA5 did not change her gloves and did not perform hand hygiene. NA5 placed a clean undergarment and a clean gown on R1. NA5 touched the other clean diaper and the hoyer pad on the chair. NA5 took the two urinals and placed them on the floor next to R1. NA5 took the soiled clothing and towel to the laundry bin. NA5 did not disinfect the bedside table after care. NA5 performed handwashing. When asked, NA5 was not able to identify lapses in infection control during care. During interview with the Director of Nursing on 3/26/20 at 12:33pm, when asked about her expectation from staff during care, the DON stated, The staff should remove the gloves and they should perform hand hygiene or hand sanitizer. When going inside the resident's room, the staff should wash their hands and put on new gloves. The DON further stated, After they (staff) remove the pants and the pull-ups, they should remove their gloves and do handwashing. They have to apply new gloves. Then they clean resident with BM, after that, they again remove the dirty gloves, do handwashing and apply new gloves when they grab a clean diaper to apply on a resident. The dirty diaper goes to garbage can. The soiled linen should go inside a clear bag and take it to the yellow barrel. Review of facility's policy titled Using Gloves dated 3/2017 revealed, #3. Wash hands after removing gloves. Review of facility's policy titled Handwashing/Hand Hygiene dated 1/2017 revealed, When to wash hands .after handling soiled or used linens . Review of facility's policy titled Cleaning and Disinfection of Environmental Surfaces dated 1/2014 revealed, Non-critical environmental surfaces include bed rails, some food utensils, bedside tables, furniture, floors .Most non-critical items can be decontaminated where they are used .Non-critical surfaces will be disinfected with an EPA-registered Intermediate or low-level disinfectant according to the label's safety precaution and use direction.#15. Spills of blood and other potentially infectious materials will promptly be cleaned and decontaminated. In a CDC article titled, Hand Hygiene in Healthcare Settings with a review date of 1/31/20, revealed, Change gloves and perform hand hygiene during patient care if . moving from work on a soiled body site to a clean body site on the same patient . https://www.cdc.gov/handhygiene/providers/index.html In a CDC article titled Guideline for Hand Hygiene in Health-Care Settings dated 10/25/02, revealed, Hand hygiene is required regardless of whether gloves are used or changed. Failure to remove gloves after patient contact or between dirty and clean body-site care on the same patient must be regarded as nonadherence to hand-hygiene recommendations .handwashing or disinfection should be performed after glove removal .improved hand-hygiene practices reduce the risk of transmission of pathogenic microorganisms. https://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf#page=19 3. A. On 3/25/20 at 10:57am, R8 was observed sitting on her wheelchair. R8 was holding her oxygen cannula (used to deliver supplemental oxygen directly into the nostrils) exposed, not covered or in a plastic bag. R6's used one-liter clear plastic IV (intravenous is passing of nutrient or medication into a vein through a tube) bag was observed exposed behind R8's back. Registered Nurse2 (RN2) confirmed the following: R8's O2 (oxygen) cannula was exposed, there was no plastic bag to place her O2 cannula and a R6's used IV bag on R8' wheelchair.

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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) RN2 stated, R8 sometimes does not want her oxygen. When RN2 was asked if it was okay that R8 was holding her O2 cannula and what they should do when a resident refuses her oxygen, RN2 further stated, We have to roll it and place it in a plastic bag. When asked why R6's used IV bag was on R8's wheelchair, RN2 stated, It should not be there. Review of R8's [DIAGNOSES REDACTED]. Review of R8's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 3/4/20 revealed a BIMS (Brief Interview for Mental Status checks the resident's attention, orientation and ability to register and recall new information) score of 6, severe cognitive impairment. Review of R8's order dated 11/23/19 revealed, On continuous oxygen 3 (three) liter, maintain oxygen saturation above 92% B. On 3/25/20 at 12:59pm, R16's nebulizer cup and mouthpiece was observed on top of the bedside dresser exposed, not covered or in a plastic bag. This was confirmed by LPN2. When asked, LPN2 stated, It should be in a plastic bag. During interview with the DON on 3/26/20 at 11:36am, when asked about her expectation from staff on used IV bags and on the care of O2 tubing, the DON stated that the nurses should have disposed of the IV bag properly. The DON added, The O2 tubing should be in a bag when not in use. The neb mask/mouthpiece should be placed in the Ziploc bag and placed it in drawer or on top of table. Review of facility's policy titled Oxygen Administration with revised date of 11/2013, revealed under General Guidelines, 1.e., Oxygen tubing will be covered and stored when not in use. Review of facility's policy titled Administering Medications via Intravenous Administration with revised date of 11/2013, revealed under Steps in the Procedure, #10. Discard used supplies in appropriate receptacles. Review of facility's policy titled Cleaning and Disinfecting Nebulizer Equipment dated 1/2014 revealed, Disinfectant the equipment every other day. Use a solution recommended by the nebulizer manufacturer, or mix (half) cup of white vinegar with 1 (one and a half) cups of water to use as a disinfectant. Pour the mixture into a small basin. Place the nebulizer cup, mask or mouthpiece into the mixture for 30 minutes. Remove the parts from the mixture and rinse under running water. Allow the parts to dry completely before putting them in storage bags. In an article titled, Caring for your nebulizer revealed, Properly maintaining your nebulizer accessories and parts is essential to your health and safety .Designate a safe place to store nebulizer unit and supplies . https://justnebulizers.com/pages/caring-for-your-nebulizer In an article titled Nebulizer Treatments revealed, After each treatment: rinse all pieces. Air dry on a clean towel. Store the dried nebulizer cup and tubing in a plastic bag. https://www.chw.org/medical-care/asthma/asthma-medicine-devices/nebulizer-treatments 4. A. On 3/25/20 at 11:08am, Nursing Assistant (NA1) was observed when he entered R15's room and removed a blanket from on top of the wheelchair. NA1 brought the blanket to R9's room and placed it on R9's recliner. NA1 did not perform hand hygiene prior to leaving R9's room. When asked if he should be taking out linens from one resident's room and bring it to another resident's room, NA1 stated, I am getting them ready. I know it's not right to take it. B. On 3/26/20 at 8:59am, Laundry Staff (L3) was observed folding linen close to her body and the linen was touching her clothing multiple times. L3 was on her cell phone while doing the task. L3 turned off her cell phone and placed it in her pocket. L3 did not perform hand hygiene. When asked if it's acceptable that she did not perform hand hygiene after using her cell phone and folding the linen too close to her clothes, L3 stated, No. During interview with the Director of Nursing on 3/26/20 at 12:33pm, when asked about her expectation from staff about linens, the DON stated, Any linen in a resident's room should remain in that room to prevent contamination. When asked about use of cell phones while folding the clean linens, the DON stated they should not use their phones. Review of facility's policy titled Laundry and Linen Policy with revised date 1/2014, revealed, The purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen .General Guidelines #18. Wash hand before handling clean linen .Steps in the procedure - In the laundry, #1. Do not allow linen, clean or soiled to touch clothing or uniform. 5. A. On 3/26/20 at 9:43am, Licensed Practical Nurse (LPN1) was observed during provision of care to R18. LPN1 checked R18's oxygen level, temperature and blood pressure. LPN1 did not disinfect the pulse oximeter (electronic device that measures oxygen level in the blood) and the thermometer. LPN1 placed the pulse oximeter and the thermometer in her pocket. LPN1 placed the BP (blood pressure) cuff and the stethoscope (instrument for listening to the action of the heart or breathing) on her right arm and gave R18 his medication. LPN1 removed her gloves and washed her hands. LPN1 hung the BP cuff and the stethoscope on the side of the medication cart. LPN1 did not disinfect the blood pressure cuff and the stethoscope. LPN1 applied hand sanitizer and prepared R14's medication. LPN1 took out the pulse oximeter and thermometer from her pocket. LPN1 checked R14's oxygen level, temperature and blood pressure. LPN1 did not disinfect the pulse oximeter and the thermometer. LPN1 put the pulse oximeter and thermometer back in her pocket. LPN1 did not perform hand hygiene. LPN1 gave R14 his medications. LPN1 washed her hands. LPN1 hung the BP cuff and the stethoscope on the side of the medication cart. LPN1 did not disinfect the blood pressure cuff and the stethoscope. When LPN1 was asked about proper disinfection of medical equipment, LPN1 stated, The pulse oximeter should be disinfected after each patient. Yes, I missed that. I cleaned the blood pressure cuff and the stethoscope before I start my shift. I used the Sani-cloth (disinfecting) wipe. B. On 3/26/20 at 10:14am, Registered Nurse (RN1) was observed performing dressing change on R5's right lower leg wound. R5 was on contact isolation for MDRO infection on his right leg wound (Multi-drug resistant organism - a group of bacteria that constantly finding new ways to avoid the effects of antibiotics used to treat the infections they cause. MDRO occurs when the germs no longer respond to the antibiotics designed to kill them). NA6 assisted RN1 during the procedure. R5's bedside table which he used during mealtimes was used to hold the wound supplies during the dressing change. R5 and NA6 did not disinfect the bedside table after the procedure. When asked, RN1 stated he thought NA6 did the cleaning and disinfection of the bedside table. Review of R5's order dated 3/9/20 revealed, Single room contact isolation for MDRO/ACINETOBACTER of the right lower leg wound. C. On 3/26/20 at 11:26am, RN3 was observed checking R7's blood sugar. Using the Sani-cloth wipe, RN3 wiped the top and bottom of the glucometer (device to test the amount of sugar in the blood) and immediately disposed the Sani-cloth wipe. RN3 did not provide adequate wet time. When asked about what she did, RN3 confirmed that she did not let the disinfecting wipe stay on the meter for 2 minutes. RN3 further stated that after she wiped the glucometer, she should have waited to let it dry completely before storing it back in the cart. I wait for two minutes. RN3 used a Fora G20 glucometer. During interview with the Director of Nursing on 3/26/20 at 12:33pm, when asked about her expectation from staff when disinfecting the glucometer, the DON stated, They're (nurses) supposed to use the Sani-cloth and leave it on the machine until dry. For the BP cuffs and pulse oximeter, the DON stated that nurses should disinfect it with Sani-cloth after use for each resident. Review of the FORA G20 manufacturer's guide revealed, Cleaning and disinfection are different. Cleaning is the process of removing dirt, disinfection is the process of killing germs .The meter must be cleaned prior to disinfection. Use one disinfecting wipe to clean exposed surfaces of the meter thoroughly and remove any visible dirt or blood or any other body fluid with the wipe. Use a second wipe to disinfect the meter .#2. Wipe all meter's exterior surface display buttons. Hold the meter with the test strip slot pointing down and wipe the area around the test slot but be careful not to allow excess liquid to get inside. Keep the meter surface wet with disinfection solution for a minimum of 2 minutes for Micro-Kill wipes. Review of facility's policy titled Cleaning and Disinfection of Resident-Care Items and Equipment dated 1/2014 revealed, 1d. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscope, durable medical equipment) .3. Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturers' instruction. Review of facility's policy titled Wound Care dated 1/2014 revealed, #19. Use clean field saturated with alcohol to wipe overbed table .#21. Wipe reusable supplies with alcohol as indicated (i.e., outside of containers that were touched by unclean hands, scissor blades, etc.) . In a CDC article titled Infection Prevention during Blood Glucose Monitoring and Insulin Administration dated 3/2/11, revealed, The Centers for Disease Control and Prevention (CDC) has become increasingly concerned about the risks for transmitting [MEDICAL CONDITION] virus (HBV) and other infectious diseases during assisted blood glucose (blood sugar) monitoring and insulin administration .If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared. https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html In a CDC article titled Disinfection and Sterilization with review date of 5/24/19, revealed, Ensure that, at a minimum, noncritical patient-care devices are disinfected when visibly soiled and on a regular basis (such as after use on each patient or once daily or once weekly). https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html#anchor_ 6. On 3/25/20 at 11:31am, R3's urinal was observed on top of bedside dresser with no barrier or covering. R3 was laying in bed and R3 had a foley catheter attached to the drainage bag. LPN4 confirmed there was no barrier in between the urinal and the surface of the table. During interview with NA2 on 3/25/20 at 11:41am, when asked if R3's urinal should be on top of the bedside dresser, NA2 stated, No. When asked where should R3's urinal be stored, NA2 stated, In the bathroom. During interview with LPN1 on 3/25/20 at 1:50pm, when asked where R3's urinal should be placed, It's supposed to be in the bathroom. On 3/25/20 at 11:41am, R2's

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) urinal was observed on the floor without a barrier. This was confirmed by NA2. When asked if R2's urinal should be on the floor without a barrier, NA2 stated, No. But he picks it up when he needs it. During interview with the DON on 3/26/20 at 12:33pm, when asked where staff should put the urinal, the DON stated, Urinal should be in the bathroom with resident's initials and date. The DON stated, For continent residents, it should be within reach. Review of facility policy titled Cleaning and Disinfection of Resident Care Items and Equipments with revision date of 1/2014, revealed, Single Resident-use items are cleaned and disinfected between uses by a single resident and disposed of afterwards (e.g., bedpans, urinal). According to a CDC article titled,Cleaning and Disinfecting Strategies for Environmental Surfaces in Patient Care Areas under I.D. revealed, Use barrier protective coverings as appropriate for noncritical surfaces that are 1) touched frequently with gloved hands during the delivery of patient care; 2) likely to become contaminated with blood or body substances. Under VI.K., it revealed, Use disposable barrier coverings as appropriate to minimize surface contamination. https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5210a1.htm