STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145891	A. BUILDING _____ B. WING _____	**08/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARRIAGE REHAB & HEALTHCARE	**1660 SOUTH MULFORD ROCKFORD, IL 61108**

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 ensure staff used personal protective equipment in a manner to prevent cross contamination when caring for residents on the facility's designated COVID19 wing and failed to perform hand hygiene to prevent cross contamination for 7 of 7 residents (R10, R12, R13, R14, R15, R16, R17) reviewed for infection control in the sample of 18. The findings include: The facility's resident roster dated August 17, 2020 showed R10, R12, R13, R14, R15, R16, and R17's reside on the COVID unit in the facility. On August 18, 2020 at 8:55 AM, V7 (Admissions) said the facility has 4 COVID positive residents and 3 residents under investigation for COVID. On August 18, 2020 at 9:40 AM, V8 RN (Registered Nurse) said she is working on the COVID hall. V8 said they have both residents who are suspected to have COVID and COVID positive residents residing on her hall. V8 identified R10, R12, R14, and R15 as being COVID positive and R17 as being suspected of having COVID19. V8 said she wears the same washable gown on the COVID hall during her entire shift and then when she is ready to leave for the day she places the gown in the laundry bin to be washed. V8 said if she wanted double protection she could put a disposable gown on over top of the washable gown and could put a surgical mask over top of the N95 mask she was wearing. On August 18, 2020 at 9:32 AM, just inside the door to the COVID unit there was a yellow washable isolation gown stuck between the hand rail and the wall. At 9:43 AM, V8 was seen entering R17's room and exiting with a handful of surgical masks. V8 crossed the hallway where there was alcohol based hand rub (ABHR) and put the surgical masks under her arm and in direct contact with the yellow washable isolation gown. V8 used the ABHR and then removed the surgical masks from under her arm. At 9:45 AM, V8 walked down to the exit of the unit, removed her yellow washable isolation gown, stuffed it in between the handrail and exited the unit without performing hand hygiene. At 9:48 AM, V8 came back to the wing and was seen putting on the yellow washable isolation gown from between the handrail and the wall. V8 was walking down the hall when there was an overhead page for V8 to pick up a phone call. V8 turned back around and removed the gown again, stuffed it in between the hand rail and the wall and exited the unit again, without performing hand hygiene. At 12:55 PM, V8 was observed returning to the unit and putting on the gown from the handrail and then taking it back off immediately and exiting the hall again without performing any hand hygiene. On August 18, 2020 at 9:32 AM, V11 CNA (Certified Nursing Assistant) said she was working the COVID unit today. At 9:40 AM, V11 was wearing a yellow washable isolation gown. V11 entered a storage room and hung her gown over a chair in the room. V11 left her gown on the chair and went across the hall to another storage room . V11 returned to the original storage room, put the yellow washable isolation gown on and went into R10's room to provide care. V11 exited R10's room at 9:50 AM and retrieved a new pair of gloves from the isolation bin outside of R10's room. V11 put the gloves on and then went back into R10's room. V11 exited the room moments later with dirty linens. V11 dropped the laundry off in the soiled utility room, took another pair of gloves from the isolation bin outside of R10's room, and then went into R15's room. V11 was wearing the same gown throughout all observations. V11 was observed wearing the same yellow washable gown into V10, R14, R15, and R17's rooms. On August 18, 2020 at 12:20 PM, V16 CNA said, I have to wear a gown, gloves, face shield, and an N95 mask with a surgical mask over it if I go into a room. I have to clean my face shield, do hand hygiene, and chang my surgical mask, gloves, and gown to go into another room. V16 said there is no personal protective equipment in the isolation bins on her hall to change into to. On August 18, 2020 at 12:25 PM, observations were made of 3 isolation bins on the isolation hall and 2 of the 3 bins had no gowns stocked. On August 18, 2020 at 12:30 PM, V2 (Regional Director of Clinical Operations) said staff are to change gowns every time they enter a room on the isolation halls. The facility's policy with revision date of January 2020 titiled Infection Prevention and Control Program showed, .Standard: The primary mission is to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility's policy with revision date of June 1, 2020 titled COVID-19 Exposure Control Plan showed, .Standard: It is the standard of this facility to protect our residents, staff, and others who may be in our facility from harm during emergency events . 7. Interventions to prevent the spread of respiratory germs within the facility: . Educate staff on proper use of personal protective equipment and application of standard, contact and droplet precautions, including eye protection . Make PPE, including facemask, eye protections, gowns, and gloves, available immediately outside of the resident's room The facility's Personal Protective Equipment (PPE) Use policy and procedure issued March 2018 showed, . Remove a soiled gown as promptly as possible and wash hands to avoid transfer of microorgamisms to other residents or environments . 1. Wash and dry hands, 2. Use a fresh gown each time one is needed To remove the gown 7. Add used, disposable gown to waste containers, 8. Wash hands or use waterless antiseptic hand rub .

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.