STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145382	A. BUILDING _____ B. WING _____	04/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE MANOR	1301 LEE STREET DES PLAINES, IL 60018

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**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 properly prevent the spread of infections such as COVID-19 as evidenced by failures to: (1) ensure that blood pressure (BP) cuff and pulse oximeter (medical device used to measure pulse and oxygen saturation level) shared among residents were properly cleaned and disinfected after each resident use for two (R1 and R2) residents; (2) follow infection control practices related to the use of glucometer (medical device used to measure sugar levels in the blood) for two (R3 and R4) residents; (3) perform hand hygiene when delivering meal trays for residents residing on second floor; and, (4) follow infection control practices related to the storage of clean linens for one floor. Staff failures to disinfect shared medical equipment, handle medical equipment to prevent contamination, perform hand hygiene while delivering meal trays and properly store clean linens to prevent contamination had the potential to affect all residents who resided in the facility at the time of the survey. Findings include: 1. Review of R1's and R2's current care plans revealed that they had [DIAGNOSES REDACTED]. In addition, some diabetes-related health issues, such as nerve damage and reduced blood flow to the extremities, increase the body's vulnerability to infection.). A. Observation of Licensed Practical Nurse (LPN1), on 4/16/20 at 11:21am, revealed LPN1 used the vital signs (VS) machine with BP cuff and pulse oximeter to check R1's BP, pulse rate and oxygen saturation level before giving R1 her medications and inhalation medication. After using the VS machine, LPN1 positioned the VS machine behind the nurses' station without sanitizing the BP cuff and the pulse oximeter. In an interview with LPN1 on 4/16/20 at 12:43pm, LPN1 verified that she checked R1's BP, pulse rate and oxygen level. When LPN1 was asked about the facility's policy on sanitizing the VS machine, LPN1 stated, Clean every shift. In this situation (with the COVID-19 pandemic), we're supposed to clean it every after resident. When asked if LPN1 sanitized the BP cuff and pulse oximeter after use with R1, LPN1 verified that she did not do it. B. On 4/16/20 at 12:15pm, the Registered Nurse (RN2) was observed entering R2's room with the VS machine. After leaving R2's room, RN2 brought the VS by the nurses' station. Another nurse (RN3) took the VS machine and plugged it to a wall socket for charging. Neither RN2 nor RN3 sanitized the VS machine. In an interview with RN2 and RN3 on 4/16/20 at 12:32pm, RN2 verified that she checked R2's BP, temperature, pulse rate and oxygen saturation in his room. When asked if the BP cuff and pulse oximeter were sanitized after she used it with R2, RN2 verified that she did not sanitize it. When asked about the facility's policy on sanitizing BP cuff and pulse oximeter in between resident use, RN3 stated, We clean it at the start of the shift then every four hours by the resident assistant. In an interview with the Director of Nursing (DON) on 4/16/20 at 3:47pm, when told about the observations of nursing staff not sanitizing the BP cuff and pulse oximeter in between resident use, the DON stated, They should have disinfected it after using with one resident. Review of the facility's Cleaning and Disinfection of Resident-Care Items and Equipment with the last revision date of November 2019 revealed under Procedure: .(1) Non-critical resident-care items include .blood pressure cuffs .(2) Most non-critical reusable items can be decontaminated where they are used .d. Reusable items are cleaned and disinfected or sterilized between residents .3. Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident; 4. Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturers' instructions . 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 . 2. Review of R3's and R4's current care plans revealed that they had [DIAGNOSES REDACTED]. In addition, some diabetes-related health issues, such as nerve damage and reduced blood flow to the extremities, increase the body's vulnerability to infection.). Observation of RN1, on 4/16/20 at 11:41am, revealed RN1 used the EvenCare G2 glucometer to check R3's blood sugar in R3's room. Without using any barrier, RN1 sat the glucometer on R3's bedside table. After disinfecting the glucometer, RN1 checked R4's blood sugar in R4's room at 11:46am. Before checking R4's blood sugar, RN1 washed her hands for only 10 seconds then RN1 sat the glucometer on R4's over-bed table without using any barrier to protect the glucometer from contamination by the surface of the table. After the procedure, RN1 washed her hands for approximately 10 seconds. In an interview with the DON on 4/16/20 at 3:47pm when told about the observation of nursing staff sitting the glucometer on residents' bedside and over-bed table without using any barrier, the DON stated, It is not acceptable to sit the glucometer on the table. The DON further stated, They should use a gray tray and a liner. When asked how long the nurse should have washed her hands, the DON stated, 20 seconds. Review of the facility's undated Blood Glucose Monitoring Skills Checklist revealed that it did not address the use of a barrier protective covering when performing glucose monitoring. According to a Centers for Disease Control and Prevention (CDC) article titled, Guidelines for Environmental Infection Control in Health-Care Facilities published on 6/6/03 under Recommendations - Environmental Services on subsection Cleaning and Disinfecting Strategies for Environmental Surfaces in Patient Care Areas, .3. 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 . Review of the facility's undated Handwashing Skills Checklist revealed, .NOTE: Direct caregivers must rub hands together vigorously, as follows, for at least 20 seconds, covering all surfaces of the hands and fingers . 3. Observation on 4/16/20 at 11:56am revealed that the Restorative Aide, Activity Aide, Nursing Aide (NA1), NA2, NA3, NA4 and NA5 were distributing lunch trays to the residents on second floor. None of these staff members was observed doing hand hygiene before delivering the lunch trays in the dining room and to the resident rooms. In an interview with the DON on 4/16/20 at 3:47pm, when told about the observations of lapses in hand hygiene by nursing and ancillary staff while distributing meal trays to the residents on second floor, the DON stated, (They should do) hand hygiene in between trays. Review of the facility's COVID-19 policy and procedure, revised on April 1, 2020, revealed under II. Prevention Within the Facility, .13. Perform hand hygiene upon exiting patient rooms and when passing trays in-between residents . 4. Observation of the linen cart on first floor, on 4/16/20 at 10:57am, revealed that the linen cart was not covered. In an interview with RN1 on 4/16/20 at approximately 11am when told about the linen cart that was not covered, RN1 stated, It is supposed to be covered with a green cover, like a nylon cover. RN1 further stated, They could be considered not clean or contaminated if not covered. In an interview with the Director of Nursing (DON) 4/16/20 at 3:47pm when told about the observation of a linen cart not being covered on first floor, the DON stated, It (linen cart) should be covered. When asked why the linen cart should be covered, the DON stated,

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 -** Many	(continued... from page 1) To prevent spread of infection. Review of the facility's Linen Handling and Washing - use of PPE policy and procedure, last revised on November 2019, revealed under PROCEDURE: The following procedures shall apply to the handling of linens: .7. All linen carts should be covered .