STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145593	A. BUILDING _____ B. WING _____	04/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE OF LIBERTYVILLE	1500 SOUTH MILWAUKEE AVENUE LIBERTYVILLE, IL 60048

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, 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 clean linen was handled to prevent contamination for one (R1) resident; (2) perform hand hygiene when appropriate during resident rounds for three (R2, R3 and R4) of three residents; and, (3) perform hand hygiene when delivering room trays for four (R5, R6, R7 and R8) of four residents in the sample of 8. Findings include: 1. Review of R1's current care plans revealed under Focus, Antibiotic therapy to treat BLE (bilateral lower extremities) [MEDICAL CONDITION] . Further review of R1's care plans revealed that R1 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 the Occupational Therapist (OT) on 4/7/20 at 10:30am revealed that the OT was carrying clean linens (bed sheet and hospital gown) and was holding them against her uniform when she went to R1's room. The same observation revealed that the bed sheet fell on the floor but the OT picked it up and placed it under R1's legs. In an interview with the OT on 4/7/20 at 10:43am when asked about the facility's policy on handling linens, the OT stated, (I) don't remember being trained about it. When asked about the linens she brought into R1's room, the OT stated, I brought a (hospital) gown and he was bleeding from his legs. The dressing was leaking so I brought a sheet to protect the wounds on lower extremities. When told about the observation of the sheet falling on the floor, the OT stated, It fell on the floor but I probably used the opposite side. When asked if she should have used it after it fell on the floor, the OT stated, I should not have. I would have to be more attentive next time. In an interview with the Acting Director of Nursing/Infection Preventionist on 4/7/20 at 1:29pm, when told about the observation of the OT's way of handling the clean linens, he stated, As a general rule, it should not be touching (the) clothes. Consider (the) clothes dirty. When told about the sheet that fell on the floor which the OT still put under R1's legs with [MEDICAL CONDITION], the Infection Preventionist stated, No, no, no. Review of the facility's Infection Control Manual: Chapter 2 - Practice Guidelines dated 5/2013 under Linen Handling Practices revealed that it did not address the appropriate way of handling clean linen. The policy and procedure related to preventing wound infection was requested from the Infection Preventionist and Administrator but was not provided. 2. Review of R2's current care plans revealed that R2 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.). Review of R3's current care plans revealed under Focus, The resident has C. (,[MEDICAL CONDITION].) Difficile (a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon). Further review of R3's care plans revealed under Interventions, CONTACT ISOLATION . Review of R4's current care plans revealed that R4 had [DIAGNOSES REDACTED]. Observation of the medical doctor (MD) on 4/7/20 at 10:35am revealed that the MD went to R2's room. From R2's room, the MD went to R3's room who was on contact isolation due to [DIAGNOSES REDACTED]icile infection. After visiting with R3, the MD wore gloves and went to R4's room and closed the door behind him. The MD was not observed performing hand hygiene in between resident room visits. In an interview with the MD on 4/7/20 at 10:57am, the MD stated, I only talked to the residents. In an interview with the Infection Preventionist on 4/7/20 at 1:29pm, when told about the above observations, he stated, He should still follow isolation precautions. Review of the facility's Infection Control Manual: Chapter 2 - Practice Guidelines dated 5/2013 revealed under Hand Hygiene, Hand hygiene is the single most important measure for reducing the risk of the spread of infection. Hand hygiene is part of standard precautions. It can reduce the transmission of healthcare associated infections to patients and staff .Consistent practice of good hand hygiene procedures reduces healthcare associated infections by preventing the spread of microorganisms. The following is a list of some situations that require hand hygiene: .before and after entering isolation precaution settings .before applying gloves . 3. Observation on 4/7/20 at 12:38pm revealed that a nursing assistant (NA1) brought lunch trays to R5's, R6's, R7's and R8's rooms. NA1 was not observed performing hand hygiene before delivering the lunch trays to the four rooms. NA1 assisted in setting up the lunch trays on R5's, R6's, R7's and R8's over-bed tables then left their rooms without doing hand hygiene. Review of R5's current care plans revealed under Focus, Hematological condition r/t (related to) Myelodysplasti[DIAGNOSES REDACTED] (a bone marrow disorder in which the bone marrow does not produce enough healthy blood cells which could make a patient susceptible to infection). Review of R7's current care plans revealed that R7 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.). Review of R8's current care plans also revealed that R8 had [DIAGNOSES REDACTED]. In an interview with the Infection Preventionist on 4/7/20 at 1:29pm, when told about the observations of lapses in hand hygiene by nursing staff while delivering meal trays to residents' rooms, the Infection Preventionist stated, They should do hand hygiene between trays. Review of the Infection Control Manual: Chapter 2 - Practice Guidelines dated 5/2013 revealed under Food Preparation, Holding and Service Practices, Principles of food preparation, holding and service practices include: .wash hands frequently . Further review revealed that it did not address hand hygiene when staff was delivering meal trays to resident rooms.

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.