

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>145261</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>06/12/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>PINE ACRES REHAB &amp; LIVING CTR</b>		STREET ADDRESS, CITY, STATE, ZIP <b>1212 SOUTH SECOND STREET DEKALB, IL 60115</b>	
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  <b>Level of harm - Minimal harm or potential for actual harm</b>  <b>Residents Affected - Many</b>	<p><b>Provide and implement an infection prevention and control program.</b></p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Based on observation, interview, and record review the facility failed to utilize PPE (Personal Protective Equipment) to prevent cross contamination for 61 of 71 residents reviewed for infection control. The findings include: The facility census dated 6/11/20 showed 71 residents. Facility roster sheets dated 6/11/20 showed 8 residents tested positive and 12 residents tested negative for COVID-19 on the north hall. The roster sheets also showed 30 residents tested positive and 10 residents tested negative for COVID-19 on the south hall. Roster sheets showed 10 residents reside on the dementia unit, all which tested negative for COVID-19. 1. On 6/11/20 at 10:05 AM, V4 (Licensed Practical Nurse) was seated at the north hall nurse station. V4 was wearing an isolation gown with her name hand written on the front. V4 said there are both positive and negative residents residing on the north hall. V4 stated she was the dirty nurse today which means she is assigned to the COVID-19 positive residents on the hall. V4 said a second clean nurse is assigned the medication pass for the COVID-19 negative residents on the hall. V4 said she did the 8:00 AM medicine pass to all the COVID-19 positive residents while wearing a mask, gown, gloves, and face shield. V4 said she wore the same gown she was currently wearing. V4 said she only removes her gloves and face shield when exiting the COVID-19 isolation rooms. V4 said she wears the same isolation gown the entire time she is on the unit and removes it only if exiting the north hall unit. On 6/11/20 at 12:00 PM, V4 re-entered the north hall unit and donned the same hand labeled gown she was wearing earlier. V4 entered the medication room and performed the noon medication pass for four COVID-19 positive residents. Each resident had a red isolation sign posted outside the rooms. V4 returned to the medication room wearing the same contaminated gown after leaving each isolation room. V4 stated the medication room is shared with the same nurse that is assigned to the COVID-19 negative residents. V4 continued wearing the contaminated gown while utilizing the medication room computer, pulling resident medication cards out of the cart, touching counter tops, door handles, and cabinets multiple times. V4 stated both dirty and clean nurses work out of the medication room. V4 said the COVID-19 positive residents are on contact and droplet precautions. Germs can be spread either way. On 6/11/20 at 12:30 PM, V1 (Infection Control Coordinator) stated staff should be removing their gowns before exiting an isolation room. If the contaminated gown is left on there is the potential to spread the germs to other residents and even staff. It is not appropriate to continue to wear isolation gowns outside of an isolation room, unless the entire unit is on isolation. 2. On 6/11/20 between 9:27 AM and 10:20 AM, staff were observed on the south wing walking in and out of both COVID-19 positive and negative resident rooms. Staff wore the same PPE in all resident rooms on the south unit. At 9:27 AM, V8 CNA (Certified Nursing Assistant) walked out of room [ROOM NUMBER]. Wearing the same PPE she wore in room [ROOM NUMBER] (except the gloves), V8 walked into room [ROOM NUMBER] and asked the resident if she was ready to lay down. V8 exited room [ROOM NUMBER] and walked down the hall to get assistance from V10 (CNA) for a transfer. V10 exited the resident room she was in and walked down the hall with V8. V10 was wearing the same gown and N95 mask she wore in the previous resident room. Both CNAs walked back down the hall, entered room [ROOM NUMBER] and closed the door. At 10:20 AM, V7 RN (Registered Nurse) wore the same gown and N95 mask he had on since this surveyor entered the south hall into room [ROOM NUMBER] to give R2 her medication and adjust her feet on her foot rests. Staff were not removing isolation gowns with each exit of COVID-19 positive resident rooms. On 6/11/20 at 9:20 AM, V7 RN said staff use the same N95 mask for one week. Staff wear the same gown in all rooms on the south wing because all of the residents are positive. (Facility rosters show both negative and positive residents on the south wing.) On 6/11/2020 at 9:35 AM, V14 (Housekeeping Aide) said the housekeeping staff wear the same gowns in all of the isolation rooms they clean unless it becomes soiled. At 9:53 AM, V13 (Agency CNA) said on the south wing, staff wear gloves, a gown, an N95 mask, a face mask, and a face shield in the positive resident rooms. V13 said staff wear the same PPE except for the gloves in all of the resident rooms on the south unit. The facilities COVID-19 Personal Protective Equipment Policy dated 2020 states under the Recommendations for Gown Use in the Setting of COVID-19 Outbreak section-If a COVID-19 patient is not cohorted in a covid-19 unit, gowns and gloves must be discarded before leaving the room. 3. On 6/11/20 between 9:27 AM and 12:30 PM, staff were observed wearing PPE gowns and masks on both the north and south units. Staff members stored the gowns in individually labeled bags between uses. On 6/11/20 at 10:05 AM, V4 (LPN) stated she uses her isolation gown for one week. V4 said, I assume it is good for one week. I haven't been told when to get a fresh gown or mask. V4 said she has not had any shortages with PPE supplies. On 6/11/20 at 10:30 AM, V6 (CNA) stated, I don't know how long to use my PPE. I've use the same stuff since this pandemic started. It has been a couple of weeks now. I am using the same gown and mask for about three weeks. I feel like I am putting dirty stuff on over and over. I have been told to only get new PPE if it becomes visibly dirty. There is plenty of PPE, but no one has taught us when to replace our PPE for fresh supplies. On 6/11/20 at 9:53 AM, V13 (Agency CNA) said the facility has implemented extended use of PPE. We re-wear the gowns. I have been here every day since Monday and this is the same gown. On 6/11/20 at 10:23 AM, V7 (Register Nurse) said the facility has sufficient supplies of PPE. The facility has implemented extended use of some PPE. V7 stated, I have had my N95 mask for about one and a half weeks and this gown for 10 days. V7 said his gown is not a washable gown. On 6/11/20 at 10:13 AM, V9 (Speech Therapist) stated, They told us to reuse the gowns as long as they are not soiled, but we use them for about a week then replace them because it just doesn't feel clean. We use the N95 masks for a week. On 6/11/20 at 10:00 AM, V11 (Medical Records/Purchasing) said at first the facility had trouble getting PPE. V11 said, Then we got in contact with someone at IDPH and now we have got everything we need for PPE. On 6/11/20 at 10:29 AM, V10 (CNA) said the staff were told to reuse the gowns for multiple days. We wear the same gown the entire shift. We wear the same gown into all of the residents' rooms on the south hall. We fold the gown and put it in a paper bag at the end of our shift. We use the same gown the next shift we work. V10 said the facility has enough PPE. On 6/12/20 at 11:55 AM, V1 (Infection Control Coordinator) stated I have been following the CDC (Center for Disease Control and Prevention) website for guidance on PPE use. V1 stated we have been reusing gowns and masks based on the extended use recommendations. V1 said we had a limited supply of PPE starting on 5/23/20, when the first positive case of COVID-19 was discovered. V1 said we followed extended use guidance while the facility wide testing was in place (5/26 and 5/27). We were unsure at that point if we would run out but getting supplies has been fine. V1 said we have plenty of PPE now. We are regularly getting isolation gowns, masks, gloves, and face shields from the local health department and local hospital. We have not had any issues with PPE supplies yet we are continuing to follow the CDC guidance as if we were in a crisis mode. The CDC website guidance under the Strategies to Optimize the Supply of PPE and Equipment states: CDC's optimization strategies for PPE offer a continuum of options for use when PPE supplies are stressed, running low, or absent. Contingency and then crisis capacity measures augment conventional capacity measures and are meant to be considered and implemented sequentially. As PPE availability returns to normal, healthcare facilities should promptly resume standard practices.</p>		
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.