STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145358	A. BUILDING _____ B. WING _____	**09/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARISTA HEALTHCARE	**1136 NORTH MILL STREET NAPERVILLE, IL 60563**

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 follow standards of infection control practices with regards to donning of personal protective equipment (PPE) and performing hand hygiene during provision of care. This applies to 7 of 9 (R4, R5, R11-R13, R18 and R19) observed for infection control practices. The findings include: 1. On 9/22/20 at 9:10am, R18's door signage showed R18 on droplet isolation precautions and no sign for contact precautions. V25 and V26 (Both CNA students) entered R18's room without proper PPE. When prompted, both V25 and V26 could not tell why R18 was on droplet isolation. V25 and V26 both walked out of the room and was going to ask V12 (Nurse). On 9/22/20 at 9:15am, V12 stated R18 should be on contact isolation for Carbapenem-resistant [MEDICATION NAME] (CRE) in the rectum and not on droplet precautions. V12 stated R18 did not have the right signage on. Upon entering R18's room to perform incontinence care, V26 placed wet wash clothes on R18's foot bed board, changed her gloves twice and failed to perform hand hygiene. During the process, V25 walked out of R18's room with her isolation gown and gloves to grab more wash clothes and came back to R18's room to assist with R18's care. V25 failed to remove her gown or gloves while going in and out of R18's room. Review of R18's physician order [REDACTED]. The POS also showed an order dated 1/14/20 for CRE in the rectum. Review of R18's minimum data set ((MDS) dated [DATE] showed R18 requires extensive assistance of one or two staff with bed mobility, transfer, dressing, toilet use and personal hygiene. The MDS showed R18 with impairments on one side of upper and lower extremities. R18's MDS showed R18 with bladder and bowel incontinence. 2. On 9/15/20 at 10:30am, V14 Certified Nursing Assistant (CNA) and V25 (CNA student) were to perform incontinence care to R5. V14 and V25 donned pair of gloves and transferred R5 from a motorized wheelchair to bed. V14 brought in some wet wash clothes and placed it on R5's bedside table. Without changing her gloves, V14 used the same wet wash clothes from the bedside table to perform incontinence care on R5. V14 then changed her gloves and failed to perform hand hygiene before assisting R5 with dressing. Review of R5's MDS dated [DATE] showed R5 requires extensive assistance of one or two staff with bed mobility, transfer, dressing, toilet use and personal hygiene. The MDS showed R5 with impairments on both sides of upper and lower extremities. R5's MDS showed R5 is frequently incontinent of bladder and bowel. 3. On 9/22/20 at 10am, V16 (CNA) entered R17's room with no isolation gown or gloves. V16 stated R17 was not on isolation and that the isolation signage on the door was for R17's roommate. On 9/22/20 at 10:05am, V8 (Nurse) stated R17 is on contact isolation for CRE and that gown and gloves should be worn prior to entering R17's room. Upon entering R17's room, R17 was noted with large bowel movement. V16 removed his gloves, failed to perform hand hygiene before donning another pair of gloves. V16 threw the soiled linens on the floor in R17's room. V16 removed the soiled linens and was taking it outside R17's room to throw in the dirty basket before he was prompted by V2 Director of Nursing (DON) to use the dirty linen basket in R17's room. Review of R17's physician order [REDACTED]. extensive assistance of one or two staff with bed mobility, transfer, dressing, toilet use and personal hygiene. R17's MDS showed R17 is incontinent of bladder and bowel. 4. On 9/17/10 at 11am, V19 and V14 (both CNAs) were in R4's room to perform incontinence care. V19 placed wet wash clothes on R4's bedside drawer. V19 used the same set of gloves to perform incontinence care on R4. Then, V19 needed to transfer R4 to a wheelchair, V19 changed her gloves, failed to perform hand hygiene prior to transferring R4 from bed to her motorized wheelchair. Review of R4's MDS dated [DATE] showed R4 requires extensive assistance of one or two staff with bed mobility, transfer, dressing, toilet use and personal hygiene. The MDS showed R4 with impairment on one side of upper and lower extremities. R4's MDS showed R4 is incontinent of bladder and bowel. 5. On 9/15/20 at 10am, V10 (Housekeeper) was observed wearing a surgical mask underneath her chin. V10's nose and mouth were exposed. V4 was seen walking in the hallway where residents (R11, R12, R13) and other staff were present. On 9/22/20 at 11:03am, V2 (DON) stated all staff are supposed to wear mask properly in the building. V2 stated this is part of the facility's COVID-19 protocols. V2 stated staff should be aware of the type of isolation residents are placed in order to don proper PPE when entering isolation rooms. V2 further stated nursing staff are supposed to place wash clothes in basin while performing incontinence care to residents. Review of facility's policy titled, 'Hand Washing Policy' dated 9/2014 showed Hand washing will be practiced as follows: b. before and after resident contact. d. immediately after glove removal .

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE