STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145699	A. BUILDING _____ B. WING _____	**07/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVANTARA OF ELGIN	**1950 LARKIN AVENUE ELGIN, IL 60123**

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 hand washing, donning and doffing of personal protective equipment (PPE), disposal of isolation garbage bags and indwelling catheter care on the COVID unit. This applies to 6 of 9 residents (R2, R4, R6-R9) reviewed for infection control practices. The findings include: 1. On 7/22/20 at 10am, V7 (Housekeeper) was cleaning R4's room in the COVID-19 designated unit. V7's cleaning cart was outside R4's room. R4 was sitting in a chair in the room. V7 came out of R4s room, removed his pair of gloves, failed to perform hand hygiene, and removed his blue isolation gown. V7 went ahead and pulled out new isolation gown from the bin (isolation set up) outside R4's room, don the gown and pair of gloves without performing any hand hygiene. Review of R4's record showed R4 was identified as positive for COVID-19 on 7/2/20. 2. On 7/22/20 at 10:02am, V7 entered R7's and R8's room to clean the room. R7 and R8 were both co-horted in the same room. V7 was cleaning all surfaces in R7 and R8's room. V7 came out of the room and removed his dirty gloves and his isolation gown and failed to perform hand hygiene. V7 used his bare hands to remove a new gown from the bin and donned the gown and a pair of gloves. Review of R7's record showed R7 was identified as positive for COVID-19 on 7/17/20. Review of R8's record showed R8 was identified as positive for COVID-19 on 7/18/20. 3. On 7/22/20 at 10:15am, V7 was coming out of R6's room. V7 just finished cleaning R6's room. V7 removed his gloves and his isolation gown and failed to perform hand hygiene. V7 also removed his isolation gown with his bare hands. V7 then removed a clean isolation gown and donned it. V7 also donned a pair of gloves. Review of R6's record showed on R6 was identified as positive for COVID-19 on 7/4/20. 4. On 7/22/20 at 10:24am, V7 was cleaning R9's room. V7 came out with the cleaning products and placed some of the items on the cleaning cart. V7 removed his pair of gloves and his isolation gown and failed to perform hand hygiene. V7 donned another isolation gown and pair of gloves. Review of R9's record showed R9 was identified as positive for COVID-19 on 7/8/20. Throughout these observations, V7 failed to perform hand hygiene each time he removed his gloves after cleaning the residents' rooms. 5. On 7/22/20 at 10am, upon entering the facility's designated COVID unit, multiple garbage bags were seen on the floor of the unit. V7 stated the isolation bags were from night shift and should have been removed. Some of the bags were against the double door that leads to the next unit. 6. On 7/22/20 at 10:05am, while speaking with V6 (Certified Nursing Assistant/CNA) on the hallway of the COVID designated unit, R2's indwelling catheter collection bag was lying on the floor in his room. R2 was asleep. V6 stated the indwelling bag should have been off the floor. Review of R2's record showed on R2 was identified as positive for COVID-19 on 7/20/20. R2's Physician order [REDACTED]. On 7/22/20 at 11:05am,V3 (Infection Control Nurse) stated V7 should have performed proper hand hygiene after removing dirty gloves or prior to donning another gloves and gowns in between residents. V3 also stated garbage bags on the COVID unit floor should have been taken out by housekeeping staff. V3 further stated that R2's indwelling catheter bag should not have been placed on the floor and should have been enclosed in the blue bag. On 7/22/20 at 11:41am, V2 (Director of Nursing/DON) stated staff is supposed to perform hand hygiene when gloves are removed. V2 stated housekeepers were supposed to pick up the garbage bags lying on the floor in the COVID unit. Facility's policy titled PPE donning/doffing options for LTCFs during cluster of COVID-19 infections with no revise date showed (1). Remove gloves. (2). Remove gown. (3). Perform hand hygiene. Facility's policy on Infection Prevention and Control with a revised date 5/29/20 was reviewed. The policy showed Isolation garbage will be disposed of properly by the housekeeping department and will be collected by an outside company for disposal. The policy also showed Handwashing for 15 to 20 seconds will be required for all staff after direct patient contact and after each situation that necessitates handwashing.

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