STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145443	A. BUILDING _____ B. WING _____	10/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROLLING HILLS MANOR	3615 16TH STREET ZION, IL 60099

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 -** Immediate jeopardy **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 implement infection control policies and recommendations from the local health department regarding isolation of COVID-19 residents; regarding cohorting of COVID-19 residents; and proper Personal Protective Equipment usage. This failure has the potential to infect high risk residents with COVID-19 and spread the disease to COVID-19 negative residents. This applies to 6 of 15 residents (R2, R4, R6, R8, R11, and R12) reviewed for infection control practices in the sample of 15. This failure resulted in Immediate Jeopardy. The Immediate Jeopardy began on [DATE] when the facility began receiving positive COVID-19 results. The Immediate Jeopardy was identified on [DATE]. V1 (Administrator) was informed of the Immediate Jeopardy on [DATE]. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on [DATE] ; however, noncompliance remains at a Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. The findings include: 1. The facility's COVID-19 Resident Line Listing, provided on [DATE], showed 29 residents were in isolation for positive COVID-19 test results. The report also showed that 6 residents died within days after being diagnosed with [REDACTED]. R2 was in her wheel chair with her lunch in font of her. R1 was in her wheelchair, near the window, with her lunch as well. Their door was not shut. The curtain was pulled halfway and residents were within sight of each other. R2's COVID-19 test results, which were collected on [DATE] and reported on [DATE], showed the Result to be Not Detected. The lab result showed, A Not Detected (negative) test result for this test means that [DIAGNOSES REDACTED]-CoV-2 RNA was not present in the specimen above the limit of detection. R1's COVID-19 test results for the same dates as R2, showed the result to be Detected. The lab test showed, A Detected result is considered a positive test result for COVID-19. This indicates that RNA from [DIAGNOSES REDACTED]-CoV-2 was detected, and the patient is infected with [MEDICAL CONDITION] and presumed contagious. (R1 and R2 were together in the same room for 5 days after the facility was aware of positive test results) The facility's Room/Bed list showed R1 and R2 were roommates. 2. On [DATE] at 11:32 AM, R4 was observed in her room. R4's roommate, R3, was not in the room and R3's bed was stripped. On [DATE] at 3:53 PM, V5 Infection Preventionist stated, R3 was sent to the hospital on [DATE] for a fever and an oxygen saturation of 88%. V5 stated she was admitted to the hospital with [REDACTED]. R3's COVID-19 test, collected on [DATE] and reported on [DATE] showed the result to be Detected. R4's COVID-19 test, collected on [DATE] and reported on [DATE] showed the result to be Not Detected. R3's [DATE] Nursing Notes showed, she was given 650 milligrams of [MEDICATION NAME] for a fever at 7:42 AM. ([MEDICATION NAME] lowers a persons fever) R3's Vital Signs showed a temperature of 100 degrees Fahrenheit on [DATE] at 1:38 AM. R3's [DATE] 8:10 PM Nursing Note showed, .Resident developed a temp of 100.7 around 17:45 (5:45 PM) and had SpO2 at 88% (Oxygen saturation percentage). Resident noted with heavy congestion and phlegm in oral airway. Suctioned performed .copious amounts of sputum suctioned . (R4 was her roommate during this time and had tested negative for COVID-19) The Centers for Disease Control and Prevention (CDC) website titled Preparting for COVID-19 in Nursing Homes updated [DATE] showed, Evaluate and Manage Residents with Symptoms of COVID-19. Ask residents to report if they feel feverish or have symptoms consistent with COVID-19. Actively monitor all residents upon admission and at least daily for fever (T=100.0 degrees Farenheit) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions as described below. The facility's Room/Bed list showed R3 and R4 to be roommates. 3. On [DATE] at 2:20 PM, R5 and R6 were seen in the same room together. R5 and R6's names were on the door. R5 was sleeping in her bed closest to the door. R6 was in her bed closest to the window. The door to R5 and R6's room was open to the hallway. R5's COVID-19 test, collected on [DATE] and reported on [DATE] showed, the result to be Detected. R6's COVID-19 test, collected and reported the same dates as R5 showed, the result to be Not Detected. The facility's Room/Bed list showed R5 and R6 to be roommates. (5 days after positive test results) 4. On [DATE] at 2:10 PM, R7 and R8 were seen in the same room together. R8 was nearest the door and sitting in her wheelchair and R7 was nearest the window working on a puzzle; neither resident wearing a mask. The door to R7 and R8's room was open. On [DATE] at 2:10 PM, R8 stated, No one asked me to move rooms .No one asked me to move because of COVID, if they did I would have to think about it. On [DATE] at 12:30 PM, V6, R8's Power of Attorney stated, she was never contacted about moving R8 or R8 refusing to move. V6 said I would remember that. V6 said, had she been notified that R8 had refused to move she would have attempted to persuade her to move. R7's COVID-19 test, collected on [DATE] and reported on [DATE] showed, the result to be Detected. R8's COVID-19 test, collected and reported the same dates as R5 showed, the result to be Not Detected. The facility's Room/Bed list showed R7 and R8 to be roommates. (5 days after positive test results) 5. On [DATE] at 2:25 PM, R9 and R12 were observed in a 4 bed room and to be in the beds closest to the door. R11's and R10's beds were not visible from the door due to the curtains being pulled; R11 and R10 were not visible. Outside the room, R9-R12's names were on the door. R9 was in bed and R12 was sitting at the edge of the bed attempting to get up to the bathroom on her own. On [DATE] at 3:53 PM, V5 Infection Preventionist stated, R11 is in the facility and is roommates with R9 and R12. V5 stated, R10 was sent to the hospital on [DATE] due to an X-ray showing atypical pneumonia. V5, said R10 was admitted to the hospital for pneumonia. R9's COVID-19 test, collected on [DATE] and reported on [DATE] showed the result to be Detected. R10's COVID-19 test, as documented on the facility Resident Line Testing showed she was Positive and the facility was aware on [DATE]. R11's COVID-19 test, collected on [DATE] and reported on [DATE], showed the result to be Not Detected. R12's COVID-19 test, collected on [DATE] and reported on [DATE], showed the result to be Not Detected. (R11 and R12 cohorted with two COVID positive residents.) The facility's Room/Bed list showed R9, R10, R11, and R12 to be roommates. On [DATE] at 1:05 PM, V5 stated she was aware that COVID-19 positive residents should not be roomed with COVID-19 negative residents and the roommates of COVID-19 positive residents she be separated and monitored for signs and symptoms of COVID-19. On [DATE] at 9:15 AM, V4 Lake County Contagious Disease Program specialist for Long-Term Care stated she had spoken with V5 on [DATE]. V4 said they had discussed the plan of action after receiving the COVID-19 positive results. V4 said, We discussed how important it was to cohort staff and residents on the COVID unit to try and prevent the further spread of COVID. We would never make that recommendation to keep a COVID positive resident with a COVID negative resident. That would be the definition of high risk exposure due to a confined room, no mask, and for greater than 15 minutes. On [DATE] at 12:58 PM, V3 Facility's Medical Director stated, It's an obvious, 'No,' they should not have a positive roommate with a negative roommate. V3 said, If a resident tests positive and another tests negative then they should be segregating the two, to try and preserve the lack of infection in the negative resident. V3 said complications of COVID-19, besides mortality, include increased clotting which can lead to [MEDICAL CONDITION] and [MEDICAL CONDITION]; pneumonia; exacerbation of other health conditions such as heart failure; and if nothing else they come out the other side much weaker and drained. The facility wide testing conducted on [DATE] and reported to the facility on [DATE] showed R4, R6, and R12 were now Detected or positive for COVID-19. The Centers for Disease Control and Prevention (CDC) website titled Responding to COVID-19 Considerations for the Public Health Response to COVID-19 in Nursing Homes showed, If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) designated COVID-19 care unit. Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents . The facility's COVID-19 Testing Plan and Response Strategy showed, If patents have been screened and their testing is Positive for COVID-19 .Private room or cohort with another symptomatic/positive patient. 6. On [DATE] during initial tour of the facility, COVID-19 positive residents and COVID-19 negative residents were observed on all 4 wings of the facility. COVID-19 positive rooms were seen with their door open to the hallway. The same staff were observed caring for both COVID-19 positive and COVID-19 negative residents. No plastic boundaries were observed, PPE requirements were not posted on resident doors, no specific COVID-19 unit was observed. Staff were observed sitting in alcoves on the units. On [DATE] at 2:25 PM, V7 Certified Nursing Assistant entered R9-R12's room to assist R12 (A COVID-19 positive room.) On [DATE] at 2:30 PM, V7 stated she cares for both COVID-19 positive and negative residents on her hallway. On [DATE] at 1:05 PM, V5 Infection Preventionist stated, We wanted to cohort the residents but the struggle was staffing. V5 said, the facility did not receive all of the test results until Friday, [DATE]. V5 stated, The DON (Director of Nursing) and I discussed what we were going to do and on Friday we were going to have to move a lot of them . (Many COVID-19 results were available on [DATE] (Thursday) as of [DATE], 5 days later, COVID-19 residents and staff had not been cohorted.) On [DATE] at 9:15 AM, V4 Lake County Contagious Disease Program Specialist for Long-Term Care stated she had spoken with V5 on [DATE]. V4 said, We discussed that they needed to move the COVID positive residents to one wing; I believe we discussed the 400 wing, and move the roommates of the COVID positive to quarantine wing and keep close monitoring on them. I think we picked 400 wing because that was where most of the positives were. Our advice would be to leave COVID positive on that wing and to move the COVID negative to a quarantine wing with close monitoring. We discussed how important it was to cohort staff and residents on the COVID unit to try and prevent the further spread of COVID. On [DATE] at 12:58 PM, V3 Facility's Medical Director stated, The last I heard they did have a COVID unit, and when they had residents who were positive on the same unit as negative residents they were putting plastic over the door to contain the spread. On [DATE], observations made during intial tour, showed no plastic sheeting over resident door ways. The facility's COVID-19 Testing Plan and Response Strategy Revision date [DATE] showed, Focus on decreased staff rotation and cohort staff who work with symptomatic residents whenever possible .Identify additional isolation rooms limiting to single unit if possible, cohort like-cases if necessary (e.g., influenza with influenza, COVID-19 with COVID-19) . On [DATE] at 3:53 PM, V5 Infection Preventionst stated all of the residents who were negatvie for COVID-19 and were living with COVID-19 positive roommates, had been roomates as of [DATE] or earlier. 7. On [DATE] at 11:25 AM, V8 Certified Nursing Assistant (CNA) was observed on the 300 hall. V8 was wearing a face shield, N95, surgical mask over N95, washable gown, and a disposable gown over the washable gown. V8 entered 3 COVID-19 positive rooms, one of the rooms she left and entered a second time. Upon leaving the COVID-19 positive rooms, V8 did not remove her disposable gown. The 300 hall also houses COVID-19 negative residents. On [DATE] at 11:30 AM, V8 stated she only changes her disposable gown after she is finished caring for the COVID-19 residents. V8 stated she does care for negative and positive in the same day. V8 stated there has been a shortage of disposable gowns at the facility. On [DATE] at 1:05 PM, V5 stated, the facility has enough disposable gowns to meet their needs and has not had difficulty obtaining them. V5 said, staff should change their disposable gowns after caring for COVID-19 residents. The Centers for Disease Control and Prevention (CDC) website titled Responding to COVID-19 Considerations for the Public Health Response to COVID-19 in Nursing Homes updated [DATE] showed, Ensure the resident is isolated and cared for using all recommended COVID-19 PPE. Place the resident in a single room if possible pending results of [DIAGNOSES REDACTED]-CoV-2 testing. Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated [DATE] showed, The PPE recommended when caring for a patient with suspected or confirmed COVID-19 includes the following: Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use. The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy. 1. On [DATE] the facility began seperating COVID-19 positive roommates from their COVID-19 negative roommates 2. On [DATE] the facility completed the process of cohorting COVID-19 positive staff and residents onto one unit. 3. On [DATE] the facility began training of staff and developed a plan to educate staff who were not on duty. Training included PPE usage, signage indicating COVID-19 positive residents, identification of COVID-19 signs/symptoms, and actions taken for COVID-19 like symptoms. 4. On [DATE] the facility developed plans for cohorting COVID-19 positive staff and residents. 5. On [DATE] the facility developed plans for to ensure policy and procedures were consistent with CDC guidelines regarding COVID-19 6. On [DATE] the facility developed a plan to minimize risk to COVID-19 negative residents on hallways with COVID-19 positive residents.