| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145735 | A. BUILDING _____ B. WING _____ | 09/24/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| BRIA OF RIVER OAKS | 14500 SOUTH MANISTEE BURNHAM, IL 60633 |

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) |
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| F 0689<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br><br>Based on observation, interview, and record review, the facility failed to provide one to one supervision to residents to prevent a fall incident. This has the potential to affect 2 of 5 residents (R1 and R10) reviewed for fall. R1 and R10 both were indicated as needing one to one supervison but were left alone. As a result, R1 fell and substained a head injury. Findings include: 1. R1's nurse's note documented R1 had a fall on 7/16/2020 with injury to her nose, was sent to the hospital, and had three suture to her nose. On 9/11/2020, V25, Licensed Practical Nurse, (LPN) documented in R1's progress note R1 had a sitter who left to go and get her dinner tray, and resident fall and sustained a bump to her head by the time the sitter came back. R1's care plan, dated 8/11/2020, indicated that R1 requires assistance with ADL and needs 1:1 supervision related to poor decision-making skills, and is supposed to be assisted with turning and repositioning every two hours and as needed. Review of the facility staffing schedule on 9/11/2020 indicated that no one was assigned as a sitter for R1 on second shift. On 9/23/2020 at 2:53PM, V25 (LPN) said R1 had a sitter on 9/11/2020, the day she fell , and sustained the injury, but the sitter left to get her dinner tray, came back and found R1 in bed with a hematoma to the left side of her head.V25 added as documented in nurse's note, and as stated during interview with V25 on 9/23/2020 at 2:53PM, R1 had a sitter on 9/11/2020, the day she fell and sustained the injury, but the sitter left to get her dinner, came back and found R1 in bed with a hematoma to the left side of her head.V25 added R1 depends on wheel chair for ambulation, does not walk fast and leans on objects to move from one place to another, requires staff assistance for ADLs, but will try to get up on her own. She also said it should have taken a person about 4 to 5 minutes getting a dinner tray from the lobby. She added V25 was assigned to R1 as the sitter on that day. On 9/23/2020 at 3:12PM, V24, Certified Nurses Assistant (CNA), stated he was not assigned as a sitter for R1 on 9/11/2020. He came to work and realized the schedule had not been made for the day. He was then assigned to move a patient from the second to the third floor with another C.N.A, to create a room for an incoming new admission. R1 was sleeping when he came to work, and there was no sitter with her from day shift. He added the schedule is never ready when they get to work, they have to wait for the charge nurse to make the schedule and assign the sitter for R1, and on 9/11/2020, he was given the moving of patient assignment once he got to work. No one told him he was assigned the sitter for R1. The Director Of Nursing (DON) interviewed him and he told her the same thing, and he also wrote a statement. V24 added that R1 has been on 1:1 for a while and the expectation for the staff assigned to a 1:1 resident is to closely monitor the resident, especially when they are at risk for fall. There is no documentation or policy on 1:1 supervision, staff are told verbally, and they do not complete any flow sheet or documentation while working with the resident. On 9/23/2020 at 4:06PM, V23, Assitant Director Of Nursing (ADON), stated R1 was on a 1:1 supervision on 9/11/2020, she was not present when the resident fell , but was made aware when she came in on Monday. She added they conducted investigation to determine the root cause analysis, and the restorative department will do follow-up investigation by getting statements from everybody. V23 added that R1 is unstable but will try to get up from her wheel chair, she is not combative. V23 said that the assigned 1:1 staff have to focus on the resident and does everything for that resident, they are not supposed to come out to get trays, other staff will usually take the tray to the resident's room. When asked how the 1:1 staff is indicated on the schedule, V23 said they always have an asterisk by the name of the person assigned to sit with a 1:1 resident. V23 presented a copy of staffing schedule on 9/11/2020 and on the second shift, there were three C.N.As and none had an asterisk by their name. V23 then said, I guess no one was assigned to the resident. On 9/23/2020 at 4:40PM, V26, CNA, said she is familiar with R1, and was at work the day she fell (9/11/2020). She was passing dinner trays about 6:30 to 6:35PM, took R1's tray to her room, and noted the bump on the resident's head. She said the resident was sitting at the edge of the bed with her pants pulled down to her feet and was not wearing any pull-ups, and was speaking in Spanish. V26 said she then called the nurse on duty and other CNAs, and tried to lay R1 down to pull up her pants. V26 said she cannot recall if resident said that she fell or if she had a sitter, but all the 3 CNAs on the unit were all passing trays. She added the primary assignment of the 1:1 staff is to focus on the resident, and you have to get a replacement if you have to leave the room, but they don't always have an assigned 1:1 staff. If they have only 3 CNAs, they all take turns watching the resident, but if they have 4, one person is usually assigned to the resiben, and on 9/11/2020, they only had 3 CNAs on second shift. V26 added that what happened was unfortunate and no can say exactly when R1 sustained the injury. On 9/23/2020 at 5:01PM, V27, (C.N.A) said he was familiar with R1, everybody was sorry for what happened. He collaborated V24's statement they were both assigned to transfer a resident from the second to the third floor at the beginning of their shift on 9/11/2020. Before they did the transfer, R1 was sleeping. Upon return to the second floor, dinner trays were up and they started passing trays. Then V27 saw R1's face with protruding injury on her face, cannot recall if she had a sitter. They wrote V24's name in the schedule but he was pulled to transfer a patient, he was not replaced with another staff. V27 added that he did not see any 1:1 staff from day shift, R1 was sleeping and was covered with a blanket when they arrived to work. 2. On 9/22/2020 at 3:18PM, surveyor conducted a random observation on the third floor and found R10, who was supposed to be on a 1:1 supervision, in a room by himself with no sitter. When confronted with this observation, V12, C.N.A, said that he just came to work and was making rounds. The schedule had not been made by the charge nurse, so R10 does not have an assigned sitter at this time. V12 also added that the sitter from day shift was supposed to wait for a relief before leaving the room. He also stated that R10 is a high risk for fall, and has had multiple falls, that is why he was placed on a 1:1 supervision. 9/23/2020 at 3:49 PM,V1, Administrator, stated the facility does not have any policy on 1:1 supervision, staff are verbally told the expectations when they are assigned a 1:1 resident. The assigned staff is supposed to focus on the resident and should not leave them alone at any time. |
| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to follow COVID infection control policy while cleaning isolation rooms for 1 of 5 residents room (R5) reviewed infection control practices. The facility also failed to adhere to infection control practices by not cleaning and decontaminating personal protective equipment (PPE) storage bins, and failed to provide disposal bins for PPE in isolation rooms for 4 of 10 (R6-R9) residents reviewed for isolation and infection control. . Findings include: R5 was readmitted to the facility on [DATE] with orders for Contact and Droplet isolation. She has an isolation sign on the door, and (Personal Protective Equipment) PPE bin outside the room with gloves, gowns, and facemask. On 9/21/20 at 2:45PM, V7 (Licensed Practical Nurse, LPN) stated that R5 is on Contact and Droplet Isolation because she is a readmission from the hospital. All readmission are Persons under investigation (PUI) remain on isolation to monitor for signs and symptoms of COVID for 14 days. On 9/22/20 at 1:13PM, V16, Housekeeper, stood outside R5's room while V14, Certified Nursing Assistant, (CNA) removed her gown and gloves. V14 asked V16 for a red biohazard bag |

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<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>and V16 handed her one. V14 left the room. V16 put on a pair of gloves and entered the room with no gown on. V16's isolation cart was outside of the door in the hallway. V16 stated that I use bleach water on her sink in the bathroom. V16 sprayed the bathroom sink and handles and wipe it right away with a rag. With the same gloves on and no gown, V16 left the room and went into the cart in the hallway to get another bottle of bleach, a bucket and a toilet brush and reentered the room. V16 poured the bleach on the toilet and used the scrub brush to clean it. V16 set the bucket on the bathroom floor and when finished washing the toilet, with the same gloves, went out into the hallway and put the bucket and scrub brush into the housekeeping cart. V16 reentered the room again to sweep the floor. When finished sweeping, she went back into the hallway and set the items on the floor. With the same gloves, V16 went into the housekeeping cart, touching multiple surfaces and took out a disinfectant solution and a mop. V16 used the mop on R5's floors and placed the mop back on the cart. V16 stated she was finished then and left the room with the same gloves on with no gown and went down the hallway, opening the housekeeping closet and touching the housekeeping cart. On 9/22/20 at 2:43pm, V3, Infection Preventionist, stated that all staff including housekeeping should wear full Personal Protective Equipment (PPE) which includes a gown and an N95 mask in isolation rooms. Housekeeping staff were in-serviced as part of the PPE as well. The concern with not wearing the PPE would be to infect another resident or staff member. On 9/22/20 at 3:23PM, V15, Housekeeping Supervisor, stated that housekeeping staff should wear gown with cleaning the room with other PPE. On 9/23/20 at 1:34pm, V15 stated that the bleach solution we use has a contact time of 5 minutes before being wiped off the sinks. The toilet brush, bucket and mops should be double bagged when done and while transported to laundry. High touch areas like call lights and the beds are supposed to be cleaned during the day. Gloves should be taken off and hands washed after use. V16 has had training regarding this. To avoid multiple trips to the hallway and back to the isolation cart, especially when cleaning the isolation rooms, items should be set up on top of the cart to assess them easily. If these procedures are not practiced, infections could be spread to staff and other residents throughout the building. Facility COVID-19 Approved disinfectants lists bleach with a contact time of 5 minutes. Facility's infection control policy related to housekeeping notes this policy is used to teach employees how to protect and prevent and spread of communicable diseases and infections such as outbreaks and cross contamination. The first steps to prevent the spread of infection include using proper personal protective equipment when cleaning an isolation room or delivering food to a resident. It is important for staff to use appropriate personal protective equipment as a barrier to exposure to any body fluids whether known to be infected or not. Ensuring that employees wash their hands after contact with any potentially infected resident or linens. Employees can be exposed to or expose residents to diseases through direct or indirect contact with equipment, contact with clothing, improper hand hygiene and using a single pair of gloves for multiple tasks. For transmission-based precautions, preform hand hygiene after cleaning the bathroom. Facility's recommendations for routine COVID-19 isolation rooms notes before entering the room, identify that there is a sign posed regarding isolation. Perform proper hand hygiene before and after entering the room. Dress in isolation clothes with personal protective equipment which includes disposable gowns. To protect the facility from the patients, every effort is made to keep the bacteria isolated by using double bag procedure for soiled cleaning until laundered. After removing gown and gloves, wash hands and forearms thoroughly for at least 20 seconds with soap and water or using alcohol-based hand rub. Be sure to follow the manufacturer's recommended dwell time (contact time) which is how long a chemical needs to be in contact with the surface in order to effectively sanitize or disinfect. Ensure surfaces stay wet for full contact time. Thoroughly clean and disinfect the patient bed area including headboard, footboard, mattress, side rails, over-bed table including the base, windowsills, chairs and remote controls. Revised policy, dated 6/2/20, notes new admissions or re-admits whose COVID-19 status is unknown will be placed on droplet/contact precautions upon admission. All recommended COVID-19 PPE should be worn during care of patients under observation, which includes use of face mask, eye protection, gloves and gown.<br><br>On 9/21/20 at 11:30AM, surveyor observed droplet precaution sign on R6 and R8's room doors, and a contact precaution sign on R7's room door of the 3rd floor. Observed a PPE bins outside of R6 and R8's rooms. Observed PPE bins outside of R6 and R8's rooms to have dust on top and outside of bins. On 9/21/20 at 12:23PM, V4, Licensed Practical Nurse, stated that R6 was readmitted from the hospital 9/18/20, R7 is on contact isolation for a multidrug resistant organism, and R8 went out to the hospital last week and was readmitted [DATE]. V4 stated that R6 and R8 are on isolation for 14 days as readmissions. On 9/21/20 from 1:19PM - 1:25PM, surveyor observed V5, Certified Nursing Assistant, delivered a meal tray to R6's room, who is in droplet precautions, without donning a gown and gloves before entering the room, without removing his face mask before exiting the rooms, and without cleaning/disinfecting his face shield after exiting the room, and then immediately delivering a meal tray to R9's room, who was not on isolation precautions. Surveyor observed V5 deliver a meal tray to R7's room who is on contact isolation, without donning a gown and gloves before entering the room, without removing his face mask before exiting the room, and without cleaning/disinfecting his face shield after exiting the room. Surveyor observed V5 deliver a meal tray to R8, who is on droplet precautions, without donning a gown and gloves before entering the room, then adjust R8's bed linens and assist R8 with setting up his meal tray. Then V5 left R8's room without removing his face mask before exiting the room, and without cleaning/disinfecting his face shield after exiting the room. On 9/21/20 at 1:50PM, V5, Certified Nursing Assistant, stated before entering residents room who are on contact or droplet precautions, staff should observe and follow the directions of the signs outside the residents room including sanitizing hands, and donning gown and gloves before entering the residents room. V5 stated that he did deliver a meal tray to R9's room after delivering a meal tray to R6's room without donning a gown or gloves. V5 stated he did not provide any direct care to R6, R7, and R8 while delivering meal trays, and therefore he did not don a gown or gloves. V5 stated he sanitized his hands and wore his face mask and face shield while delivering their trays. V5 stated he could have contributed to possible contamination due to not wearing a gown and gloves while adjusting R8's bed linens and assisting R8 with meal tray set up. V5 stated he was never told he needed to remove any of his facial PPE before exiting rooms of residents who are on contact or droplet precautions. V5 stated monthly in services on infection control practices are conducted at the facility. Observed V5 touching his mask multiple times during the interview, and V5 did not sanitize his hands. On 9/22/20 at 1:15PM, surveyor observed V19, Certified Nursing Assistant, leave R6's room after discarding her gown in R6's garbage bin. Surveyor observed R6 grab V19's used gown and place it on top of the PPE bin outside of his room that contains unused PPE. Survyeor observed V19 state to R6 he cannot put a used gown on top of the PPE bin, then leave without removing the contaminated PPE or disinfecting the bin. On 9/22/20 at 1:17PM, surveyor observed V20, Certified Nursing Assistant, obtaining PPE from the bin outside of R6's room that had a used PPE gown on top of it. V20 stated there were no PPE disposal bins in R6, R7, or R8's rooms. V18, Licensed Practical Nurse, stated it was strange that there were no PPE disposal bins in R6, R7, and R8's rooms. On 9/22/20 at 2:17PM, V3, Infection Preventionist - Licensed Practical Nurse, stated all staff entering isolation rooms must wear full PPE. V3 stated full PPE is required for residents who are quarantined or on isolation. V3 stated when staff are delivering trays they are required to don full PPE when entering those rooms. V3 stated all isolation rooms have to have PPE disposal bins inside and outside of the rooms. V3 stated if there are no PPE disposal bins inside isolation rooms, staff can contaminate others if they leave the room wearing used PPE. On 9/23/20 at 12:55PM, V3, Licensed Practical Nurse - Infection Preventionist, stated gowns, gloves, N95 masks, goggles, or face shield and a surgical masks are required PPE (Personal Protective Equipment) for communicable disease infection control. V3 stated when leaving any isolation rooms, staff must discard surgical or N95 mask and clean and disinfect goggles or face shields with non-bleach wipes. On 9/23/20 at 4:03PM, V3, Licensed Practical Nurse - Infection Preventionist, stated the PPE (Personal Protective Equipment) bins should be cleaned and sanitized by housekeeping. V3 stated if a resident places a used PPE gown on top of a PPE storage bin, staff should clean and sanitize the PPE bin with bleach wipes with a contact time of 3 minutes, and if the drawers were open when the used PPE gown was placed on top of it, the contents of the bin should be discarded and replaced. R6's Physician order [REDACTED]. The facility's PPE policy, received 9/23/20, states: Don PPE (Personal Protective Equipment) when entering the room as indicated and before contact with the resident in the following order, o Gown o Mask o Goggles/Face Shield o Gloves |