STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145868	A. BUILDING _____ B. WING _____	05/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVANTARA LONG GROVE	1666 CHECKER ROAD LONG GROVE, IL 60047

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 properly contain COVID-19 for one of three residents (R1) reviewed for infection control and 18 outside the sample. The findings include: 1. On 5/26/20 at 9:45 AM, V12 and V13 (CNAs-Certified Nurse Aides) entered the 200 wing, (COVID positive wing) via an emergency exit door at the end of the hallway. V12 and V13 walked through the entire length of the positive unit. V12 and V13 were not wearing isolation gowns or gloves. V13 exited the unit and went directly onto the COVID negative unit. V12 remained on the positive unit and touched her sweating neck line and forehead to adjust her hair covering several times. V12 adjusted her face mask several times, still not wearing gloves. V12 then exited the positive unit and entered the negative unit. On 5/26/20 at 9:52 AM, V12 (CNA) stated today was her first day back to work after being off for the past 14 days due to a positive COVID-19 test. V12 said she is caring for both positive and negative COVID-19 residents. V12 said she is required to wear an isolation gown and gloves (plus face mask and eye protection) when caring for the residents on the positive unit. V12 said she uses the emergency exit door to go out and come back into the facility during breaks. On 5/26/20 at 11:45 AM, V12 was on the positive COVID unit still not wearing an isolation gown or gloves. V12 removed clean linen from a cart on the COVID positive unit, walked directly onto the negative unit, and entered a resident room. V12 left the linens in the resident room and returned to the positive unit. Still ungloved and not wearing an isolation gown, V12 pushed the button codes on a supply room door on the positive unit. V12 entered the supply room and carried out incontinence briefs, peri wipes, and toothbrushes. V12 re-entered the negative unit with the resident supplies. V12 did not wash or sanitize her hands between units and did not don or doff an isolation gown. On 5/27/20 at 10:20 AM, V3 (Infection Control Coordinator) stated the same staff are being assigned to care for positive and negative residents. V3 said when a staff member is leaving the positive (COVID-19) side and going over to the negative side, they must first wash their hands or use hand sanitizer. V3 stated staff should also put on a fresh, isolation gown and new gloves before going onto the negative side. V3 said staff are required to wear gloves and an isolation gown 100% of the time when on the positive side of the unit. V3 said it is a huge potential for cross contamination of the COVID-19 virus when PPE (personal protective equipment) is used incorrectly or not all. V3 stated staff are required to be screened anytime they exit and re-enter the building. It is facility protocol to screen staff every time they enter the building. On 5/26/20 at 9:05 AM, V1 (Administrator) stated the facility census was 134 residents. V1 stated 98 of those residents have tested positive for COVID-19. Documentation provided by the facility on 5/26/20 showed R8-R19 reside on the COVID negative side of the 200 wing. R3 resides on the COVID positive side of the 200 wing. The facility's isolation PPE postings (undated) put out by the Centers for Disease Control and Prevention which is placed outside of every COVID positive resident room states: Use safe work practices to protect yourself and limit the spread of contamination. Keep hands away from face. Limit surfaces touched. Change gloves when torn or heavily contaminated. Perform hand hygiene. The facility's Infection Prevention and Control policy review dated 7/31/19 states under the Transmission Based Precautions section: Infection prevention practices include hand hygiene, use of gloves, gown, or mask depending on anticipated exposure . 2. R1's face sheet shows she has [DIAGNOSES REDACTED]. R1's lab results collected on 5/7/20, with results reported on 5/9/20 show R1 tested positive for Covid-19. R1's Order Review Report shows orders on 5/12/20 for physical therapy 5-6 times per week for 30 days. On 5/26/20 at 11:18 AM, V5 (Physical Therapist) exited R1's room. V5 had gloves on as he was closing R1's door. Walking down the hall, V5 removed a pair of gloves and threw them in the trash can by the nurse's desk. V5 still had gloves on after removing the pair and throwing them in the trash. On 5/26/20 at 11:20 AM, V5 said he puts multiple pairs of gloves on to provide therapy for the residents. V5 said he removes the top pair after he does physical therapy for a resident. When asked when he performs hand hygiene, V5 said after he removes the last pair of gloves he performs hand hygiene. V5 demonstrated that he had 3 more pairs of gloves on after discarding the last pair. When asked if he received training on infection control and if the training included wearing multiple pairs of gloves, V5 said he messed up. V5 said gloves should be removed and hand hygiene performed in between each resident. On 5/26/20 at 12:46 PM, V4 (Director of Therapy) said it is not acceptable for V5 to put on multiple pairs of gloves and remove the top pair in between residents. He had training on infection control and that is not what he was trained to do. V4 said V5 should remove gloves and perform hand hygiene in between residents for infection control. On 5/26/2020 at 12:50 PM, V3 (Assistant Director of Nursing) said it is not acceptable for V5 to put on multiple pairs of gloves and remove the top pair of gloves between residents. V3 said gloves should be removed and hand hygiene performed between residents. V1 (Administrator) was in the room during the interview and she repeated that gloves should be removed and hand hygiene should be performed between residents. The facility's policy and procedure titled Gloves Usage, with a revision date of March 23, 2018 shows Miscellaneous: 1. When gloves are indicated, use disposable single-use gloves. 2. Discard used gloves into the waste receptacle inside the examination or treatment room .5. Wash hands after removing gloves (Note: Gloves do not replace handwashing). The document provided by the facility on 5/26/20 shows V5 had 5 residents on the 300 hall that were scheduled to receive physical therapy on 5/26/20. The residents on the schedule were R1, and R4-R7.

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