STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145438	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLLINSVILLE REHAB & HEALTH CC	614 NORTH SUMMIT COLLINSVILLE, IL 62234

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 -** Many	**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 operationalize their COVID-19 Infection Control Policy by not implementing infection control precautions for residents who have been potentially exposed to COVID-19 and for residents whose COVID-19 status is unknown, and failed to provide appropriate Personal Protective Equipment (PPE) for staff to prevent the potential spread of COVID-19. This failure has the potential to all 58 residents in the facility. Findings include: 1.On 6/23/20 at 8:20 AM V1, Administrator, stated the current census in the facility is 58 residents. V1 stated there were currently no COVID-19 positive residents residing in the facility; however, R4 was hosptalized on [DATE] and diagnosed with [REDACTED]. V1 stated residents who are quarantined after being admitted are placed on the 100 Hall, the transition hallway and are put on contact isolation, requiring staff to wear gloves and mask when providing care. V1 stated one staff, V16, Certified Nursing Assistant (CNA), who worked midnights on the 300 Hall, tested positive for COVID-19 on 6/10/20. V1 confirmed R1 was the only resident in the facility who has been on any precautions for COVID-19. V1 stated she keeps the PPE in her office, but the nurses have a box of masks in their cart. She stated staff must wait until a department head comes in to unlock the front office if they need additional PPE. V1 stated all residents were tested on [DATE] for COVID-19 but she had not received their results yet. 2.On 6/23/20 at 8:30 AM V1 stated, (R1) is a new admit and is on quarantine for 14 days. Staff must wear a surgical mask and gloves for precautions. R1's Admission Physician order [REDACTED]. R1's Care Plan dated 6/17/20 does not include any information regarding new admission quarantine for 14 days related to potential COVID-19 exposure. On 6/23/20 at 9:00 AM, R1 left her room with a mask on and walked past the nurses' station where V3, Assistant Director of Nurse's (ADON), was passing medication to another resident. R1 proceeded to walk down the halls of 111 to 113 areas. V6 and V7, Certified Nurse's Aides (CNAs), were at the nurses' station and did not attempt to redirect R1 back to her room. On 6/23/20 at 9:05 AM, R1 walked back into her room. V7 was in R1's room wearing only gloves and a mask, but no eye protection or gown. V7 left R1's room carrying R1's laundry in her gloved hands. There was no PPE set up outside or inside R1's room, or isolation signs on R1's door indicating R1 was on any type of precautions at that time. On 6/23/20 at 9:15 AM V4, Housekeeping Supervisor, set up a 3-drawer bin outside of R1's room which contained red trash bags, gowns, gloves, and N95 masks, but did not include any type of eye protection. There were no isolation signs on the door indicating what type of PPE was required or what type of isolation precautions R1 was on. V4 stated, I was told to set up PPE for (R1) by the Administrator. I am not sure what precautions (R1) is on. Everything the staff needs is in here (PPE bin) and staff can pick out what they need. V4 stated she did not put up an isolation sign on the door as she just sets up the supplies. On 6/23/20 at 9:30 AM, V3, Assistant Director of Nursing/Infection Preventionist, stated, (R1) is on standard/contact precautions and staff are expected to wear a mask and gloves to enter her room. I was not aware (V4) set up PPE in front of R1's door. The Director of Nursing (DON) and I are responsible for setting up isolation precautions. When sked if isolation precautions should have been put in place when R1 was admitted on [DATE], V3 stated, I will put up a contact/droplet sign for (R1). I have only been in this position for 3 weeks. The DON gets the referrals and sees what's going on with the residents and knows if they are on isolation. 3.On 6/23/20 at 8:25 AM, V1 stated R2's roommate, R4, tested positive for COVID-19 when he was admitted to the hospital on [DATE]. V1 stated R4 was transferred to a sister facility after being discharged from the hospital because this facility does not accept COVID-19 positive patients and the sister facility does. V1 stated there are no residents on isolation for COVID-19 in the facility at this time. On 6/23/20 at 8:25 AM and throughout the survey, R2 was in his room in bed. There was no isolation precaution sign outside or inside his door indicating special infection control precautions were in place due to his being exposed by R4 to COVID-19. There was no PPE set up outside his door. R2's medical record was reviewed, including physician's orders [REDACTED]. On 6/23/20 at 7:55 AM, V6, CNA, stated there were no residents in the facility who were positive for COVID-19. V6 stated there were no residents in the facility who were recently admitted or readmitted , symptomatic, or requiring 14-day quarantine for COVID-19. V6 stated if a resident needed to be quarantined, the resident would be placed in a private room on the transition hallway. V6 stated any resident on the transition hallway requiring 14-day quarantine would have no special precautions in place and staff would wear a mask as a preventative measure. On 6/23/20 at 8:05 AM V9, CNA, and V10, CNA, were passing trays and ice water on the 300 Hall. Both V9 and V10 were wearing masks but did not wear any other type of PPE while passing breakfast trays room to room. V10 stated that no one on the 300 Hall had symptoms of COVID-19 or were on 14-day quarantine, and no one require any special precautions. V1 had reported in an earlier interview that V16, CNA, who had tested positive for COVID-19 on 6/10/20 had primarily worked on the 300 Hall around the time she had tested positive. On 6/23/20 at 9:20 AM, V3, ADON stated the residents on the transition hallway requiring a 14-day quarantine are on standard / universal precautions which would require staff to wear a mask and the resident to wear a mask when coming out of their room. V3 stated if a resident was a readmission or new admission, they would place them on contact precautions which would be a mask and gloves if needed. Stated staff would know a resident was on special precautions when giving report to the oncoming shift. V3 stated the DON or ADON would notify staff if special precautions were needed and would set it up. 4. On 6/24/20 at 9:05 AM during phone interview, V2, DON, stated R5, R6 and R7 had tested positive for COVID-19 and were moved to the COVID unit in the facility, along with R4, who had previously tested positive and was just readmitted from a sister facility. She stated R2, R8 and R9, who are all roommates to the COVID-19 positive residents, are still in their rooms on the 100, 200 and 300 Halls, but those residents are being isolated to their rooms, and staff are being stricter with keeping residents in their rooms. She stated the residents did not do too good at staying in their rooms before. V2 stated the residents on the COVID unit are on contact and droplet precautions, and she thinks the affected roommates are too, but stated she was not sure. On 6/24/20 at 10:52 AM during phone interview, V4, Housekeeping Supervisor, stated she was responsible for setting up the PPE for residents requiring isolation precautions. V4 stated she now has 4 PPE bins set up for isolation rooms including R1's isolation for 14-day quarantine related to coming back from the hospital, 2 PPE bins set up for the resident isolation rooms on the COVID unit for the residents with recent positive results (each room has two residents) and another PPE bin set up for a resident on isolation for a non-COVID infection. She confirmed these are the only rooms set up for isolation. V4 did not include any isolation set ups for the previous roommates of the residents, R2, R8 and R9, who tested positive for COVID-19 who would have been exposed to COVID-19. The facility's policy,COVID-19 Control Measures, revised 5/2/20, documents Admissions/Readmissions: 3.New admissions and readmissions whose COVID status is unknown, should be placed in private room and all recommended COVID-19 PPE (Personal Protective Equipment) should be worn during care of residents under observation, which included an N95 respirator or facemask if respirator is not available, eye protection, gloves and gown. Residents are to remain in a private room under observation for 14 days. The Policy documented Monitoring and Surveillance-Residents: 5. If residents are cared for by HCP

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 -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) (Health Care Provider) with known COVID-19 or suspected COVID-19, these residents should be restricted to their room and be cared for using all recommended COVID-19 PPE for a period of 14 days after last known exposure and tested should they develop symptoms. The undated Center for Disease Control (CDC) Guidance; Responding to Coronavirus (COVID-19) in Nursing Homes Considerations for the Public Health Response to COVID-19 in Nursing Homes under Considerations for new admissions or readmissions to the facility documents, Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown .All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown . Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. This Guidance continues 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 unless they remain asymptomatic and or/ have tested negative for [DIAGNOSES REDACTED]-COV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit. I added this.