STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145486	A. BUILDING _____ B. WING _____	**06/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE SPRING VALLEY	**1300 NORTH GREENWOOD STREET SPRING VALLEY, IL 61362**

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 -** Few	**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 their Infection Control policy for new admissions and readmissions related to COVID-19 for two of two residents (R2 and R3) reviewed for COVID-19 infection control in the sample of five. Findings include: The facility's Infection Control Policy - Interim policy addressing healthcare crisis related to Human Coronavirus, revised 5/5/20, documents: New Admission/Readmissions: Separate cluster of rooms for new admissions and readmissions that either were not tested or tested negative at hospital and do not have symptoms. Should identify these rooms with signage. Otherwise if no separate hallway or area is available; these residents may go to the Green Zone for quarantine monitoring x (times) 14 days under droplet precautions. Private room or cohort with another recent admission/readmission that is not symptomatic and does not have a conflicting infections such [MEDICAL CONDITION] ([MEDICAL CONDITION]- resistant Staphylococcus aureus), VRE ([MEDICATION NAME] Resistant [MEDICATION NAME]), [MEDICAL CONDITIONS], etc. On 6/4/20 at 9:35 am, V10 LPN (Licensed Practical Nurse) stated R2 and R3 are the two new admissions on C Wing and neither resident is in Droplet Isolation. V10 stated R3 is in Contact Isolation for a wound infection and R2 is not in isolation at all. 1. R2's electronic medical record documents R2 was admitted to the facility on [DATE] and does not contain any orders or documentation related to R2 being in quarantine or Droplet Isolation. On 6/4/20 at 10:10 am, V12 PT (Physical Therapist) was assisting R2 in his room. R2's roommate (R5) was lying on his bed with the door open to the hall. There was no isolation signage and no isolation set-up outside or inside of R2's room. V12 wearing a surgical mask and gloves, entered R2's room, pushed R2 out into the hallway and to the therapy room while wearing the same mask and gloves. On 6/4/20 at 10:10 am, V12 PT stated she was taking R2 to the Therapy room for an Evaluation. V12 stated she was told R2 had a negative COVID-19 test at the hospital before his admission to the facility and was not told R2 was in any level of isolation. On 6/5/20 at 1:53 pm, V2 DON (Director of Nursing) and Infection Preventionist, stated R2 was tested for COVID-19 while in the hospital and due to negative results R2 was placed in a regular room, with a roommate, without any isolation precautions. 2. R3's electronic health record documents R3 was admitted to the facility on [DATE]. R3's Physician order [REDACTED]. R3's health record does not contain any documentation regarding R3 being in quarantine or Droplet Isolation. On 6/4/20 at 9:45 am, R3's room did not have isolation signage or an isolation set-up outside or inside of R3's room. At this time, R3 was sharing a room with R4. On 6/5/20 at 1:53 pm, V2 DON (Director of Nursing) and Infection Preventionist, stated R3 was placed in a regular room, with a roommate, and is in Contact Isolation only for Osteomylitis of her foot. V2 stated R3 was tested for COVID-19 upon admission to the facility and the test results are still pending. V2 also stated the Infection Control Policy, revised 5/5/20, is the policy the facility is currently using.

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.