STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145699	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVANTARA OF ELGIN	1950 LARKIN AVENUE ELGIN, IL 60123

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 ensure residents exposed to COVID-19 were quarantined, failed to ensure Personal Protective Equipment was worn when entering a quarantined resident room, and failed to ensure proper hand hygiene after perineal care. This applies to 5 of 5 residents (R1, R2, R3, R6, and R8) reviewed for infection control practices in a total sample of 9 residents. Findings include: 1. According to the EHR, R2 had [DIAGNOSES REDACTED]. The EHR census showed R2 was a roommate with R5. The EHR showed R5 had a [DIAGNOSES REDACTED]. A Nursing Progress Note dated 08/14/2020 at 3:18 PM by V2 (Director of Nursing/DON) showed R5 Resident noted complaining of sore throat and cough. MD notified with order for CXR; resident will be moved to (another room) for PUI with symptoms - contact and droplet precaution observed. Social service to notify family. A care plan reviewed on 08/25/2020 did not show R2 was in contact precautions isolation. On 08/24/2020 at 1:40 PM, R2 did not have any signs posted indicating R2 was in isolation. At 4:40 PM with V3 (Assistant Director of Nursing/ADON/Infection Preventionist) present, it was observed R2's room did not have any sign on the door or wall indicating R2 was in any type of isolation precautions. No cart with PPE was outside of the door. V5 (Registered Nurse/RN), said R2 had not been in quarantine isolation since last Wednesday 08/19/2020 or Thursday 08/20/2020. When asked if there was a physician order [REDACTED]. V3, said Normally the facility staff will have a morning huddle and discuss who can come out of isolation; there would not be a physician order. R2 was in quarantine isolation for only five or six days. 2. According to the Electronic Health Record (EHR) R6 had [DIAGNOSES REDACTED]. On 08/24/2020 at 4:01 PM, V3 (ADON) said R6 was roommates with R9 who had tested positive for COVID-19. V3 said R9 had started exhibiting symptoms on 07/01/2020 and was sent out to the hospital on [DATE] where she had tested positive for COVID-19. R6 was placed in quarantine isolation on 07/02/2020 but was taken out of quarantine isolation on 07/10/2020 when she had a negative COVID-19 test result and didn't have any symptoms. V2 (DON) said she thought the guidance from the county health department at that time was to be in quarantine for seven to ten days. V2 said the facility's corporate office said the quarantine should be for 14 days. V2 agreed the facility did take R6 off quarantine isolation too soon. A physician progress notes [REDACTED]. The Nursing Progress Notes do not show any documentation regarding R6 being in isolation or notification to family about being in the room with a COVID positive resident. The Nursing Daily Evaluation dated 07/09/2020 does not indicate R6 was in isolation. No other Nursing Daily Evaluations were found between 06/30/2020 and 07/14/2020. R6 was in quarantine isolation for only eight days. 3. According to the Electronic Health Record (EHR) R3 had [DIAGNOSES REDACTED]. The Nursing Admission Isolation Evaluation dated 08/23/2020 showed R3 was on isolation due to new admission per protocol. On 08/24/2020 at 4:35 PM, V4 (Medical Director) and V11 (Physician Assistant) walked into R3's room only wearing mask and no other Personal Protective Equipment (PPE) such as a gown or gloves. Outside of the room was a cart filled with PPE supplies. A sign was posted on the wall next to the door indicating R3 was in isolation requiring gown, mask, and gloves to enter. V3, (ADON/Infection Preventionist) was present for this observation, V3 knocked lightly on the door and V11 came to the door. V3 told V11 they needed to be wearing PPE since R3 was in quarantine isolation. As V3 walked away from the door, V4 (Medical Director) came out of the room and asked V3 Did you need something? V3 explained to V4 anyone entering R3's room should be wearing PPE. V4 asked Why? V3 explained to V4 (Medical Director) that newly admitted residents are placed in quarantine for 14 days upon admission. V4 said But I cleared him (R3). He had a negative test result before he came here. 4. According to the Electronic Health Record (EHR) R1 had [DIAGNOSES REDACTED]. The Minimum Data Set ((MDS) dated [DATE] showed R1 needed extensive assistance of one person for bed mobility, dressing, hygiene, bathing, and toilet use, was totally dependent on two staff for transfers; needed supervision set up for eating. R1 was always incontinent of bowel and bladder. The MDS showed R1's cognition was moderately impaired. A care plan showed R1 required strict isolation due to testing positive for COVID. On 08/24/2020 at 3:05 PM, V9 (CNA) entered R1's room on the COVID unit explaining to R1 she was going to check the incontinence brief to see if it was wet. V9 already had gloves and a gown on. After checking R1's incontinence brief, V9 proceeded to change the brief and perform perineal care. V9 turned R1 to the left side and cleaned a moderate amount of soft brown bowel movement from R1's perineal area using multiple disposable wipes. V9 removed the soiled incontinence brief and wipes and threw the brief toward the garbage, missing the garbage and landed on the floor. Without removing her soiled gloves, V9 placed a clean incontinence brief under R1, rolled her onto the brief, adjusted and secured the tabs of the brief in place. Without changing gloves, V9 adjusted R1's pillow and blankets, then touched the side rail bed controls to adjust the height and head of R1's bed. V9 picked up the soiled brief from the floor, placed it into the garbage bag, removed the garbage bag, and tied it closed. V9 took the garbage bag to the large red receptacle outside of R1's room but there was no garbage liner bag in the receptacle. V9 placed the garbage bag on the floor in R1's room, with the same soiled gloves, grabbed a roll of garbage bag liners from the top of the linen cart, removed one bag, replaced the roll onto the top of the linen cart, then placed a bag into the large red receptacle before placing the soiled garbage bag into it. V9 then removed her gloves and donned new gloves without performing hand hygiene. V9 then entered another resident's room (R4's room) and adjusted R4's urinary catheter drainage bag on the side of his bed explaining there was nothing on the floor. With the same gloved hands V9 retrieved the blood pressure machine from the hallway and brought it into R4's room to do vital signs. 5. According to the EHR R8 had [DIAGNOSES REDACTED]. On 08/24/2020 at 2:40 PM, R8 had been lying in his bed. The right side of R8's body was against the wall and a fall mat was on the floor to the left side of the bed. Nasal cannula oxygen tubing was lying on the fall mat on the floor. R8 stood up from his bed onto the fall mat, stepped on the oxygen tubing, and started walking unsteadily around the over-the-bed table. No bed alarms were sounding when R8 got out of bed. This writer alerted V3 (ADON) about R8 walking in his room. V3 went into the room and guided R8 to sit down in bed over the quarter side rail. V3 assisted R8's legs over the side rail and into bed then placed the nasal cannula oxygen tubing onto R8's nares. When asked if R8 needed a new nasal cannula since it was on the floor, V3 said Yes it should be replaced. I didn't even notice it was on the floor. On 08/24/2020 at 12:28 PM, V2 said all newly admitted residents are placed in quarantine in a private room for 14 days. On 08/24/2020 at 4:01 PM, V3 stated, If someone tests positive, they go to the COVID unit and we quarantine the roommate for 14 days. V2 was also present. V2 explained the facility had a line list of residents who have tested positive or were exposed and presented the line list for review. When asked when R2 was placed into quarantine according to the list, V2 said R2 was not placed on the list as an exposure. V2 said R2 and R5 were roommates. R5 had tested positive, was isolated on the COVID unit, and was entered onto the line list. V2 said since R2 had already tested negative for COVID the facility did not place R2 on the line list but kept her in quarantine isolation precautions. V2 agreed R6 was placed on the line list as an exposure to a positive COVID resident but R2 was not entered on the line list even though she had been exposed to a COVID positive resident. V2 did not have an answer for the difference. On 08/24/2020 at 4:54 PM, V2 said the facility policy for wearing PPE in the COVID unit was to be wearing full PPE including gown, gloves, face shield, and face mask. V2 said the staff could wear the same gown between residents provided the gown does not become soiled, however the staff should change gloves between residents. The staff cannot wear the same gloves between residents. V2 said the staff

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 -** Some	(continued... from page 1) should use hand sanitizer or wash their hands between glove changes. On 08/26/2020 10:17 AM, V12 (COVID 19 LTC liaison County Health Department), said the guidance for persons who have been in close contact with a COVID-19 positive person has always been to be placed in quarantine for 14 days. V12 said the facilities receive a Long-Term Care Toolkit with guidance on how to handle COVID-19 residents for isolation and quarantine. V12 said the liaisons were available for any questions the facilities may have and the facilities are frequently reminded about the guidance. The facility's Hand Hygiene policy dated 08/05/2020 included Hand Hygiene with alcohol-based hand rub is recommended during the following situations: Before and after direct resident contact. Before and after assisting a resident with toileting. After contact with blood, body fluids or surfaces contaminated with blood or body fluids. The facility's Glove Usage policy dated 03/23/2018 included to wash hands when removing gloves. The facility's COVID 19 Guidelines and Emergency Preparedness Plan dated 05/30/2020 includes If a staff or resident has a close contact with a PUI or COVID 19 case: Monitor health from day resident first had close contact to 14 days after last contact with the person. The Centers for Disease Control (CDC) Responding to Coronavirus (COVID 19) in Nursing Homes website guidance dated 04/30/2020 includes 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). On 08/26/2020 at 3:37 PM, V1 (Administrator) said it is the facility's policy to follow the CDC guidelines of keeping the residents in quarantine for 14 days. The facility's Oxygen policy dated 08/05/2020 included oxygen setups should be changed every seven days and as needed if heavy soiling is present.