STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145434	A. BUILDING _____ B. WING _____	**07/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLARIDGE HEALTHCARE CENTER	**700 JENKISSON LAKE BLUFF, IL 60044**

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 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a dressing to a resident's pressure ulcer. R1 is the subject of this complaint. The findings include: On July 27, 2020 at 10:36 AM, V2, Director of Nursing (DON), V9, Certified Nursing Assistant (CNA), and V10, CNA went into R1's room to provide wound care. They turned her to her right side and exposed her bottom. No dressing was present. A white, pasty substance V10 identified as Calazinc (a barrier cream) was noted over R1's backside.V2 cleaned up R1's backside and revealed a small open area to the sacral area about the diameter of half a pea. V2 acknowledged R1 did not have a dressing in place, but should have. On July 27, 2020 at 12:48 PM, V3, Assistant Director of Nursing (ADON)/Wound Care Nurse, said she would expect staff to inform the nurse if a dressing came off a resident's wound and the nurse to replace the dressing. On July 28, 2020 at 7:40 AM, V3 said R1 should still be getting [MEDICATION NAME] (a wound care medication) and a gauze dressing to her sacral wound. V3 said the wound care order for R1 was written on May 5, 2020. She said the wound care doctor did not see R1 on Sunday, (July 26, 2020) so he has not discontinued the order at this time. R1's Physician order [REDACTED]. Change daily and as needed. R1's medical records show a note by her wound care physician, V13, dated July 12, 2020 (his most recent visit to R1) which shows the following: Sacral Pressure Ulcer .Site should be cleansed with normal saline, Primary Dressing [MEDICATION NAME] and 4x4 (gauze) .Frequency Twice a day and as needed . R1's POS from May 2020 to current were reviewed and no order to discontinue her [MEDICATION NAME] and gauze dressing changes to her sacral pressure ulcer were noted. The facility's Medication and Treatment Orders Policy, revised April 2014, show medications shall be administered .and Drug and biological orders us be recorded on the POS in the resident's chart.
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 wear a gown and eye protection while giving care to a resident on transmission based precautions The facility failed to screen essential workers entering the facility during a pandemic, and failed to have personal protective equipment (PPE) available outside of an isolation room. R1 is the subject of this complaint. The investigation took place on July 27, 2020. The findings include: On July 27, 2020 at 10:36 AM, V2, Director of Nursing (DON), V9, Certified Nursing Assistant (CNA), and V10, CNA entered R1's room (222) to provide wound care. R1 had signs on her door indicating she was on transmission based precautions. V2 did not wear goggles, a face shield, or any other type of eye protection. V9 did not wear a gown over his white lab jacket. R1's medical records show she tested positive for Covid-19 on July 2, 2020 and again on July 18, 2020. At 10:58 AM, V2 said she should wear eye protection in a resident's room who is on isolation for Covid-19 and then says sorry. At 11:09 AM, V9 was in room [ROOM NUMBER], R8 and R9's room wearing a white lab jacket. At 11:11 AM, V9 went to room [ROOM NUMBER] wearing the white lab jacket, R10's room, and at 11:20 AM, V9 proceeded to room [ROOM NUMBER], R2 and R11's room. V9 was still wearing the white lab jacket as he provided incontinence care to R2. At 11:11 AM, V9 said he has only one lab coat which he wears to work every day. V9 said he puts it in his car at the end of the day and brings it with him to wear during his next shift. At 11:38 AM, R10 said staff needs to wear a gown, gloves, mask, face/eye shield and a hair covering when going into a room with Covid-19 isolation needs. R10 said they wear a lab jacket all day. At 9:35 AM, R11, Registered Nurse (RN) said Covid-19 precautions require staff to wear a mask, gown, gloves, and eye shield/goggles when in the room. R11 said Covid-19 residents require isolation for 14 days, and must have no symptoms with two separate negative Covid-19 tests before isolation is discontinued. At 12:48 PM, R3, Assistant Director of Nursing (ADON)/Wound Care Nurse said she would expect staff to have an isolation gown on in any Covid-19 rooms. She said staff entering rooms with Covid-19 precautions must wear a gown, face shield, hair net, gloves and N95 mask with or without a surgical mask over it. At 9:15 AM, three Health Facility Surveillance Nurses (HFSN) from the Illinois Department of Public Health entered the facility, identified themselves and their purpose, and asked V12 (Receptionist) for his administrator. V12 escorted the three HFSNs to a conference room to wait for the facility's representative. At 1:58 PM, V12 said he screens everyone who enters the facility with a questionnaire and takes their temperature. V12 said, I know I forgot to screen you guys. His screening log for staff and a separate screening log for essential visitors was reviewed. At 12:48 PM, V3 said everyone who enters the facility has their temperature taken and screening questions are completed due to the Covid-19 precautions in place. At 10:58 AM, an isolation cart is observed outside room [ROOM NUMBER]. Upon inspection, the cart has no PPE in or on it at all (no gloves, gowns, masks, eye protection, hair coverings). V2 said she changes her outer gown and gets a new one from the supply kept downstairs in her office. At 12:48 AM, V3 said the problem is gowns are in short supply. At 9:35 AM, R11 said she has concerns about running out of PPE and supplies her own N95 mask which she changes every day. She said they were given one white lab jacket and wear them for a week, take them home to wash them and then bring them back to wear at work. The facility's Isolation-Initiating Transmission Based Precautions policy effective 5/4/2009, shows transmission -based precautions will be initiated when there is reason to believe that a resident has a communicable infectious disease. It says the infection control coordinator (or designee) shall ensure that PPE (gloves, gowns, masks, etc.) is maintained near the resident's room so that everyone entering the room can access what they need.

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.