STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	06/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

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 follow their facility COVID-19 policy regarding closing positive COVID-19 resident room doors, isolating roommates exposed to COVID-19 and staff adhering to isolation precautions to prevent the spread of COVID-19 infection. This has the potential to affect all 82 residents living in the facility. Findings include: 1. On 6/10/20 at 10:45 AM, V1, Administrator stated, there were 82 residents living in the facility. (R1) tested positive for COVID-19 on 6/9/20. V2 stated R1 had been R3's and R4's roommate prior to transferring him to a private room on 6/9/20. R1's Electronic Medical Record (EMR) dated 6/09/2020 documents R1's [DIAGNOSES REDACTED]. At 11:00 AM, V8, Certified Nurse's Assistant, (CNA), entered R1's room, closed the door, and exited the room at 11:10 AM and left the door open. At 11:15 AM, V7, Licensed Practical Nurse, (LPN) entered R1's room, left the door open, exited the room at 11:30 AM and left the door open. With continuous observation, R1's door remained open from 10:40 AM until 12:00 PM. R1's door did not have signage posted outside the door indicating the room was being used for isolation and entering the room required Personal Protective Equipment, (PPE), to be worn. On 6/10/2020 at 10:30 AM, V1, Administrator stated there was one positive COVID-19 resident in the facility, (R1). V1 stated R1 went to the hospital to have his feeding tube replaced and when he went there, he was tested at the hospital and that's when we found out he was positive on 6/9/2020. V1 stated there were 2 staff members last week that were showing COVID-19 symptoms, they were tested , and both were positive and are at home now. V1 stated When (R1) returned to the facility, we implemented our Red Zone and he was put in isolation in the Red Zone on the 100-hall. Originally, (R1) was in a room with 2 roommates (R3 and R4) and they are not in quarantine because they are not showing symptoms. The health department told me that the roommates didn't have to go into quarantine because they weren't showing symptoms. I contacted our corporate office and they also told me they didn't have to be in quarantine because they weren't showing symptoms. Staff were told to monitor (R1's) roommates for symptoms. Staff that are going into the Red Zone room are wearing full PPE, all the other staff are wearing masks only. I will call corporate and have them send me the policy for not putting roommates in isolation if they are not showing symptoms.: On 6/11/2020 at 12:00 PM, V2, Director of Nurses, (DON), stated she worked the night shift the last 2 nights and was not involved when R1 was found out to be positive with COVID-19 on 6/9/2020 and was not involved with putting R1 in the red zone. V2 stated (R1) is now on the 100-hall in the red zone room and his roommates (R3 and R4) are in their room and are not in isolation. V2 stated R1's roommates should have been kept in their room and staff are not following policy. V2 stated she trains staff and does COVID-19 testing on staff and residents but V3, Assistant Director of Nurses, ADON oversees implementing the COVID-19 Infection Control Policy. V2 stated she was told today there are more positive cases in the building, and she observed more isolation carts on all the halls and have observed room changes for residents throughout the facility. V2 stated she was aware there had been no signage on the outside door of the facility indicating the facility had a positive COVID-19 resident in the building or any signage on (R1's) door indicating isolation precautions were required and PPE needs to be worn prior to today. V2 stated just recently signage had been posted at the facility door notifying of positive COVID-19 residents and at resident's doors for isolation and the need for PPE to be worn. V2 stated the information that a resident is in isolation should be in the Kardex, Care Plan, and MDS for staff to be made aware of but wasn't sure where it would be in Point Click Care. V2 stated she was not sure who puts the information on the Kardex. 2. R3's Electronic Medical Record (EMR) dated 6/11/20 documents R3's has a [DIAGNOSES REDACTED]. The Care Plan documents Interventions: 1. Droplet precautions. 2. Private room. 3. Meals in room. 4. Activities in room. 5. Therapy services in room. 6. Education provided covering hygiene and isolation precautions. R3's MDS, dated [DATE], documents R3 has severe cognitive impairment. On 6/10/20 at 11:20 AM, V5 Certified Nurse Aide (CNA) wheeled R3 out of his room in his wheelchair and took him into the dining room and put him at a table by himself. R3 had a mask on but it was not covering his mouth or nose. There was no signage regarding isolation protocols on R3's door and no isolation cart with personal protective equipment (PPE) outside of his room. V5 had a facemask on but was wearing no other PPE including gown, gloves or goggles/face shield. When V5 left the dining room she was asked why she took R3 out of his room and took him to the dining room. V5 stated, He needs to be watched while he eats. On 6/10/20 at 11:25 AM, V5 came back into the dining room and took R3 out of the dining room and brought him back to his room. V5 stated, I didn't know (R3) was to be isolated to his room. 3. R4's EMR dated 6/11/20 documents R4's has a [DIAGNOSES REDACTED]. The Care Plan documents Interventions 1. Droplet precautions. 2. Private room. 3. Meals in room. R4's MDS, dated [DATE], documents he has severe cognitive impairment. On 6/10/20 at 11:30 AM, V4 Licensed Practical Nurse (LPN) stated, I didn't know (R3 and R4) were isolated to their room. I am taking care of both of them today and that information was not given to me in report this morning. On 6/10/20 at 11:45 AM, V1 stated, The staff know (R3) and (R4) needed to be in isolation. It is on the Care Plan and the MDS. The DON would have verbally communicated that to them, but she was working at midnight last night, so she isn't here today. So, no one verbally told the staff to place (R3 and R4) in isolation because their roommate was positive. It is the responsibility of the staff to read the Care Plan for this information. On 6/11/20 at 10:52 AM V3, stated, On 6/10/20 and 6/11/20, I was working the floor and was not working in the office. The staff should have known (R3) and (R4) should have been in isolation. They have all been in serviced. (R3) should not have been in the dining room. I don't know why there was no signage on the door and no isolation cart outside the room. I don't know when they were put in isolation, it should have been when we found out about the roommate (R1) being positive on 6/9/20. I would expect staff to wear full PPE, mask, gloves, gown, eyewear going into the room. The staff are notified about this information from the Care plan/Kardex. On 6/11/20 at 11:34 AM, V5 stated, The staff should tell you in report if a resident is in isolation and no one told me. We should have been wearing full PPE (Gowns, gloves facemask, eyewear) when going into (R3) and (R4)'s room. There was so signage on their door or isolation cart, it wasn't there when I left work yesterday (6/10/20), but it is there today. On 6/11/20 at 1:20 PM V2 Director of Nurses (DON) stated, I don't know why there was no signage on (R3's) and (R4's) door or isolation cart outside (R3's) and (R4's) room there should have been. On 6/11/2020 at 3:30 PM, V1 stated, I think there is a discrepancy in our policy. I talked with, (V9, Vice President of Clinical Services), and she told me we should have presumed (R1's) roommates (R3 and R4) were positive with COVID-19 and we should have placed (R1's) roommates (R3 and R4) in isolation and all staff should have used full PPE measures, masks, goggles, face shields, gloves and gowns, when entering their room and used droplet precautions. We got most of the results back from our testing today and we have 33 residents that are positive, 13 staff that are positive, and at this time and we have 5 pending resident results. The facility's Interim Policy regarding Addressing Healthcare crisis Related to Human [MEDICAL CONDITION], revised 5/5/20, documents When COVID 19 is identified in the facility, staff will wear all recommended PPE (Personal Protective Equipment) (i.e., gloves, gown, eye protection, and respirator or facemask) for the care of all residents on the unit (or facility-wide based on the location of affected residents), regardless of symptoms (based on availability of PPE-Refer to CDC Guidelines for Crisis

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	**06/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE JACKSONVILLE	**1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650**

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	(continued... from page 1) Capacity Strategies for preserving PPE. PPE recommended when caring for a patient with known or suspected COVID 19 includes: Respirator or Facemask, Eye Protection, Gloves, Gowns. Identification and Prevention steps: 1. Signage at the front entrance restricting all visitors. Exception only for [MEDICATION NAME] end of life visits. Care of residents that are symptomatic, Person under investigation (PUI) or confirmed positive: Residents with known or suspected COVID-19 should be cared for in a single-person room OR cohorted with another positive COVID-19 patient (this does not include PUI) with the door closed. The resident should have a dedicated (not shared) bathroom. Centers for Disease Control (CDC) website https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html Responding to Coronavirus (COVID-19) in Nursing Homes Considerations for the Public Health Response to COVID-19 documents Resident with new-onset suspected or confirmed COVID-19: Ensure the resident is isolated and cared for using all recommended COVID-19 PPE. Place the resident in a single room if possible pending results of [DIAGNOSES REDACTED]-CoV-2 testing. Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents (e.g., residents who have fever, for example, due to a non-COVID-19 illness could be put at risk if moved to a COVID-19 unit). If cohorting symptomatic residents, care should be taken to ensure infection prevention and control interventions are in place to decrease the risk of cross-transmission. If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit. 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). Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room.