STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145609	A. BUILDING _____ B. WING _____	**06/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLSIDE REHAB & CARE CENTER	**1308 GAME FARM ROAD YORKVILLE, IL 60560**

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 properly display transmission based precaution signage outside the resident's room door or at the unit entry listing the specific personal protective equipment (PPE) to be used for residents in isolation/quarantine for Covid-19. This applies to 3 of 3 residents (R1, R2, R3) reviewed for isolation precautions and PPE. The findings include: 1. R1's EMR (Electronic Medical Record) showed that R1's medical [DIAGNOSES REDACTED]. R1 is alert and oriented to self only. R1's Care Plan dated May 29, 2020 showed that R1 was to be in isolation due to testing positive for Covid-19. 2. R2's EMR showed that R2's medical [DIAGNOSES REDACTED]. R2's MDS dated [DATE] showed that R2 is cognitively impaired and required full assistance with all ADL. R2's MDS also showed that R2 was to be in isolation or quarantine for active infectious disease. R2's Care Plan dated April 27, 2020 showed that R2 was to be in strict isolation due to testing positive for Covid-19. 3. R3's EMR showed R3's medical [DIAGNOSES REDACTED]. R3's MDS dated [DATE] showed that R3 was cognitively intact and required extensive to full assistance with one staff assistance for ADL. R3's Care Plan dated June 8, 2020 showed R3 currently requires contact/droplet isolation for prevention of COVID 19 virus after hospital admission. On June 9, 2020 at 9:17 AM, V2 (DON, Director of Nursing) stated the second set of double doors (Compartment 1) is where we were putting our Covid positive residents and residents we place on quarantine after leaving the facility for something like an emergency room visit or hospitalization We have the plastic up to create a room where the staff can put on a gown before entering the unit. All staff are wearing masks at all times. They are expected to put on a cloth gown and enter unit, before going into a resident room they have to put on gloves and disposable gown on over the cloth gown. Before they leave the room, they are to remove the disposable gown and gloves and perform hand hygiene. They must continue to wear the cloth gown in the hallway. When they leave the unit, they go through double door and before they go through the plastic enclosure, they have to remove their cloth gown. There is hand sanitizer on the wall and they are expected to perform hand hygiene before going any further. On June 9, 2020 at 9:20 AM, there weren't any transmission based precautions signs on the doors leading into the unit or outside any of the residents' rooms. There were two isolation carts on the unit. One was outside R1's room and the other was outside R2's room. There was no cart outside R3's room. On June 9, 2020 at 9:25 AM, V5 (CNA,Certified Nurse Aide) and V 6 (CNA) were observed leaving a residents room. V6 came out wearing just her mask and was performing hand hygiene with alcohol based hand sanitizer. V6 then left the unit. V5 came out of room wearing mask and gloves. She was bringing out dirty linen and garbage in bags. She disposed of laundry and trash in the appropriate receptacle. V5 stated we are supposed to wear gowns when we are on this unit. Before we come through the door we put on a cloth gown before we come on the unit. When we go into a resident's room we put the disposable gown on over the cloth gown. When we come out of a resident's room, we take off the disposable gown and gloves before coming out of the room. V5 and V6 said in separate interviews that they were not wearing gowns in room [ROOM NUMBER] because that resident is being transferred to the transition unit. When we are on this unit the expectation is that we put a gown on before coming onto the unit. V5 stated that the residents on the Covid unit are on Covid isolation. V5 stated that the residents are on airborne isolation, when told that was incorrect she guessed droplet. On June 9, 2020 at 10:45 AM, V2 (DON) clarified that the staff going onto the Covid unit are to put on cloth gown on before entering the unit. They are to have the cloth gown on whenever they are in the hallway on that unit. When they go into a resident room, they are to put on a disposable gown over the cloth gown along with gloves and mask. Facility policy titled Infection Control, under section titled Covid Preparedness, it showed that it is the policy of this facility to minimize exposure to respiratory pathogens and promptly identify residents with clinical features and epidemiological risk for Covid-19 and to adhere to the federal and state/local recommendations (to include for example admissions, visitation, precautions: standard, contact, droplet and/or airborne, including the use of eye protection). On page 5 of the policy it showed, Ensure signs are posted immediately outside the resident's room indicating the appropriate IC precautions and required personal protective equipment (PPE).

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.