STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E306	A. BUILDING _____ B. WING _____	**10/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTH AURORA CARE CENTER	**310 BANBURY ROAD NORTH AURORA, IL 60542**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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 ensure infection control measures were in place to prevent the spread of COVID-19. This applies to all residents in the facility. The findings include: 1. On 10/19/2020 at 10:00 AM V1, Administrator, notified this writer there was an outbreak of COVID-19 in the facility and took this writer's temperature as part of the entrance screening process. At 12:15 PM, V1 notified this writer her COVID-19 test result had come back positive and she was trying to gather all the requested material for the survey so she could go home. V1 said the corporate office would be sending someone to replace her but they were coming from approximately two hours away. Upon reviewing the facility's COVID-19 line list, it showed V1 had tested positive for COVID-19 on 10/12/2020 and her last day of work was 10/12/2020. On 10/20/2020 at 2:59 PM V1 said she was the only staff member who had tested positive for COVID-19 who came into the facility to help with paperwork and do phone calls due to critical staffing needs. V1 said she had worked in the facility 10/16/2020, 10/17/2020, 10/18/2020, and 10/19/2020 because the corporate office was not able to send someone out to cover her position. V1 said she thought someone from the corporate office was at the facility today and would be there the remainder of the week. On 10/21/2020 at 11:06 AM V11, Housekeeper, opened the facility's entrance door wearing full personal protective equipment (PPE). V1, Administrator, exited her office to assist with obtaining this writer's temperature as part of the entrance screening process. At various times on 10/21/2020 V1 was noted to be in her office with the office door open, talking on the phone without a mask on. 2. On 10/19/2020 during multiple observations between 11:07 AM and 11:47 AM various staff members were seen entering the COVID unit without first donning full PPE. An isolation cart containing PPE was placed inside the COVID unit beyond the first resident room of R15 and R16. Both R15 and R16 tested positive for COVID-19 on 10/12/2020. The door to that resident room was open. V7, Maintenance, entered the COVID unit wearing only a mask and face shield, walked in the hallway to the maintenance closet, then walked in the hallway exited out of the COVID unit going to another unit. V8 and V9, Certified Nursing Assistants (CNAs) entered the COVID-19 unit with a beverage cart, walked past R15 and R16's room, stopped outside of R15 and R16's room with open door, then donned gowns and gloves. On 10/19/2020 at 11:37 AM V7, Maintenance, said the maintenance office was on the COVID unit. V7 said the maintenance staff doesn't really stay on the unit but they do have to go in and out of the COVID unit sometimes to retrieve items from the maintenance office. On 10/19/2020 at 11:45 AM V8 (CNA) was exiting the COVID unit. V8 said she was working on a different unit but had gone onto the COVID unit to help V9 (CNA) pass water and juice to the residents. V8 said she had to enter the COVID unit to obtain incontinence briefs and resident supplies which are kept in that unit. On 10/19/2020 at 11:59 AM V11, Housekeeper, was on the COVID unit wearing a face mask and shield but not wearing a gown. V11 said he will wear a gown if he enters resident rooms but not necessarily if he was in the hallway. V11 said he does have to clean the COVID unit as well as other areas of the facility. There was another housekeeper working also, but since the housekeeping closet was here on the COVID unit, V11 said she does have to come onto the COVID unit for the housekeeping closet. On 10/21/2020 on two separate occasions, V11 exited the COVID unit wearing full PPE and went to door of V1 (Administrators office) and Business Office door to ask questions, then returned to the COVID unit. 3. The facility's COVID-19 line list was reviewed. The following residents were noted to have tested positive for COVID-19 but not located on the COVID unit: R4, R5, R6, R7, R8, R12, and R17 tested positive on 10/15/2020; R2 tested positive on 10/17/2020. R12 tested positive on 10/18/2020 and was in the hospital. R17 tested positive on 10/21/2020. The residents were located in five different rooms on three different units. The facility's floor plan is laid out with six hallways. V1, Administrator, distinguished the units as Front, Middle, and Back units based on the nurses station. The Back unit encompasses two hallways: the north hallway and part of the west hallway. The Front unit encompasses three hallways: the south hallway, the east hallway, and the remaining west hallway. The Middle unit is parallel between the north and south hallways. on 10/22/2020 at 1:00 PM V1 confirmed the COVID unit was located on the Back unit and now also included the Middle unit due to an increase in COVID-19 positive residents. On 10/19/2020 at 1:31 PM on the middle hallway unit R4 and R5 were in a shared room with the door closed. An isolation cart for personal protective equipment (PPE) was in the hallway, but no signage was on the door to indicate if they were in isolation. On 10/19/2020 at 1:37 PM in the Front unit, west hallway, R6 was in a room with an isolation sign posted for contact droplet precautions and an isolation cart with PPE in the hallway. Across the hallway, R7 and R8 were in a room with a sign posted on the door displaying (Stop. See Nurse.) Both room doors were open. R6 was standing in the doorway and would walk into the hallway then back into the room without wearing a mask. V4, Licensed Practical Nurse (LPN) verified R6, R7, and R8 were positive for COVID-19. On 10/21/2020 at 11:46 AM R17 was standing in the open doorway to the hall wearing a mask, but telling several residents who walked past her she was positive for COVID. R17's door did not have and signs on the door or an isolation cart outside of the door. The facility's COVID-19 line list showed R17 tested positive for COVID-19 on 10/21/2020 and was a roommate with R12 with who was in the hospital and who had tested positive for COVID-19 on 10/18/2020. 4. On 10/19/2020 at 1:32 PM R2 was in a room on the Front unit, south hallway, with a closed door but no signs were noted on the door. No isolation cart with PPE was outside of R2's room. R2 said his roommate (R4) had been moved to another room in a different hallway. R2 was not in isolation even though the facility COVID-19 line list showed R2 had tested positive on 10/17/2020. On 10/19/2020 at 1:46 PM V5, Certified Nursing Assistant (CNA), was unsure why R2 did not have an isolation cart for PPE or a sign on the door. V5 said Maybe it's because we really don't have to go into his room to help him with anything. A Nursing Progress Note dated 10/17/2020 at 10:00 PM showed R2 had a temperature of 100.8 degrees Fahrenheit. R2 complained of not feeling well, weakness, and was COVID test positive. On 10/21/2020 at 11:26 AM R2 was seen exiting his room with two large bags of his belongings and walking in the hallway. The room still did not have any signs indicating R2 was in isolation, nor was there an isolation cart with PPE in the hallway. At 11:31 AM as R2 walked from the bathroom across the hallway from his room, he said the facility staff told him this morning (10/21/2020) he needed to switch to another room from the Front unit, southern hallway to the Middle Unit hallway. 5. On 10/19/2020 at 10:55 AM V4, Licensed Practical Nurse (LPN), said R1 had tested positive for COVID and now has a temperature of 99.2 degrees Fahrenheit. V4 said the Nurse Practitioner ordered R1 to be sent to the hospital for an evaluation. According to V4, R1's roommate (R5) was currently in the hospital with a positive COVID-19 diagnosis. The facility COVID-19 line list showed R5 had tested positive for COVID-19 on 10/15/2020. At 11:05 AM R1 was lying in bed on oxygen via nasal cannula. The door to R1's room was open. No signs regarding isolation were on the door, no isolation cart was in the hallway outside of R1's room. R1 was not in quarantine precautions even though he had been in contact with a R5 who had tested positive for COVID-19 four days previously. Wearing a mask and goggles, V4 (LPN) entered R1's room and told R1 he was going to take his temperature. V4 was not wearing a gown or gloves when he entered the room. On 10/19/2020 at 2:05 PM V4 (LPN) received call from hospital said R1 had tested positive for COVID-19 but was being sent back to facility. V4 wasn't sure what room R1 was going to be placed in and needed to reach out to (V1) the administrator. On 10/21/2020 at 11:31 AM R1 was lying in bed in the Middle Unit with the door open, no sign on the door to indicate isolation, and no isolation cart outside of the room. R1 said he had gone out to the hospital on [DATE] and had

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 -** Many	(continued... from page 1) returned to his original room on the Front unit, southern most hallway. R1 said the facility moved him to the Middle Unit on 10/20/2020 in the evening. 6. On 10/19/2020 at 10:53 AM R10 was propelling herself in a wheelchair in the hallway. R10 said she has had a cough for three weeks and had been tested four times for COVID-19 which have all come back negative. R10 said she can't get answers for her cough. The Nursing Progress Notes do not show R10 had any symptoms of a cough between 08/27/2020 and 10/19/2020. A Nursing Note dated 10/19/2020 at 9:00 PM showed R10 had weakness to all extremities, slow movement, alert and oriented and reported having a loose bowel movement. R10 did not have a fever but her oxygen saturation level was 94 percent on room air. an order for [REDACTED]. The facility COVID-19 line list showed R10 had tested positive for COVID-19 on 10/19/2020. On 10/21/2020 at 12:48 PM R11, (R10's roommate) was lying in bed in the Front unit, southern hallway, with the door open, no signs were on the door indicating if R11 was in isolation and no isolation cart with PPE was in the hallway. R11 was not in quarantine. R11 said R10 was moved out of their shared room on 10/20/2020 in the evening. R11 did not know why R10 was moved. On 10/21/2020 at 3:10 PM V3 (RN) said R10 was moved onto the COVID unit yesterday 10/20/2020 around 4:00 PM. 7. On 10/19/2020 at 2:17 PM R3 was walking in the front hallway without a mask on, coughing. V4, LPN, told her R3 she should have a face mask on. R3 walked into a resident room on the Front Unit, east hallway and laid down on the bed. R9 was lying in the other bed in the room. The facility Roster showed R3 should be on the COVID unit. V4 said R3 should be on the COVID unit but was one of those residents who won't comply with what the facility told her to do. aid the beds are too small over there. V4 said it was R3's room previously. V4 said it was very hard to get some of the residents to comply with the rules and R3 was one of them. On 10/19/2020 at 2:26 PM R3 was walking in the hallway again. She had on a mask below the chin but it was not covering R3's mouth or nose. V4 asked her to go back to her room on the COVID unit. On 10/19/2020 2:35 PM V3 (RN) said R3 was one of the residents who refused to wear a mask or stay in her room. V3 said R3 was on the COVID unit for quarantine due to being in the hospital, not because she was positive for COVID-19. On 10/20/2020 at 10:10 AM V2, Director of Nursing/Infection Preventionist said when R3 had returned from the hospital on [DATE] she was placed in the COVID unit for 14 day quarantine. R3 needed frequent redirecting to stay in her room but she usually returned to the room. Last week when we had to move COVID-19 positive residents onto the COVID unit, we moved R3 further toward the front of the unit further from the residents who were COVID-19 positive, but she remained on the COVID unit. The Nursing Progress Notes showed R3 was in the hospital from 09/25/2020 to 10/09/2020. The Nursing Progress Notes dated 10/10/2020 at 3:00 PM showed refused to wear a mask or stay in the room. On 10/21/2020 at 12:11 PM V3 said R3 had a chest X-ray done which showed she had pneumonia and a positive test result for COVID-19 on Monday evening 10/19/2020. The facility COVID-19 line list confirmed R3 was positive for COVID-19 dated 10/19/2020. On 10/21/2020 at 12:17 PM R3 was walking in the Front Unit middle hallway without a mask on. V12, Activity Director blocked the hallway with a cart and told R3 she needed to go back to the COVID unit. After one minute of asking, R3 finally turned around in the hallway and walked back through the hallway toward the western most hallway on the Back unit/COVID unit. On 10/21/2020 at 1:58 PM R3 was standing in the Dining Room outside of the COVID unit without a mask on. On 10/21/2020 at 2:45 PM a resident was heard on the COVID telling R3 to get out of her room, then calling out to an empty hallway (R3)'s in my room again! 8. Review of the facility's COVID-19 line list showed R13 was the first resident to test positive for COVID-19 on 10/11/2020. R13 had been in a shared room with R14. On 10/19/2020, R14 was seen in her room on the Middle unit with the door opened without a mask on. The room did not have any signs on the door to indicate R14 was in isolation or quarantine, nor was there an isolation cart with PPE outside of the room in the hallway. R14 was last in contact with R13, a resident positive with COVID-19, on 10/11/2020. Eight days later, R14 was not in quarantine. On 10/21/2020 at 12:15 PM V5, CNA, exited R14's room asking V12 (Activity Director) to wait outside R14's door, explaining she needed to get assistance because R14 was on the floor. V12 said she did not think R14 was in isolation since there weren't any isolation signs on the door or isolation cart outside of the room. V5 returned and entered R14's room without an isolation gown or gloves, saying she was the only CNA to care for all of the residents that were not in the COVID unit. at 12:27 PM V13, Registered Nurse, entered R14's room without a gown or gloves on to assess R14. 9. On 10/21/2020 at 12:11 PM V14, Hospice Nurse, exited the COVID unit and walked into the back nurse's station. V14 said she had walked through the front door, then walked through the COVID unit. At 12:36 PM V14 said she was unaware the unit she walked through was the COVID unit. V14 said she hadn't been to the facility very often and was not completely familiar with the layout. According to V14, (V1) the administrator had led V14 from the front door through the COVID unit to reach the back nurse's station. V14 said if she knew it was a COVID unit when she first entered she would have worn a gown and full PPE before she entered. 10. On 10/19/2020 at 10:55 AM V4, LPN, said several staff members have tested positive for COVID-19 so they are out on quarantine. V4 said when he was working last week Wednesday 10/14/2020 a nurse had developed symptoms during the day shift and had to leave. V4 said the nurse scheduled for the evening shift did not show up to work so V4 had to keep working until the night shift nurse arrived. V4 said he was the only nurse for the whole facility during the evening shift. The facility COVID-19 line list showed V4 was positive for COVID-19 dated 10/21/2020. 11. On 10/20/2020 at 10:10 AM V2, DON, said she wasn't feeling well with symptoms of chest pain and back pain on Wednesday 10/14/2020. V2 said she went to the hospital emergency room and was diagnosed with [REDACTED]. V2 said she was working at the facility taking care of residents on Thursday 10/15/2020. At 3:00 PM at the end of the shift, V2's symptoms were still present. V2 had a COVID-19 rapid test done at the facility before she left on 10/15/2020 which came back positive. The facility's COVID-19 Control Measures policy revised 10/01/2020 showed the purpose was to prevent transmission of the COVID-19 Virus and to control outbreaks. The policy included New admissions and re-admissions whose COVID status is unknown, should be placed in a private room and all recommended COVID-19 PPE should be worn during care of residents under observation, which includes an N95 respirator, eye protection, gloves and gown. Residents are to remain in a private room under observation for 14 days. The policy also includes If residents are cared for by a HCP with known COVID-19 or suspected COVID-19, these residents should be restricted to their room and be cared for using all recommended COVID-19 PPE for a period of 14 days after last known exposure and tested should they develop symptoms. The policy does not address how to treat residents who were in contact with other residents who are positive for COVID-19.