STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145967	A. BUILDING _____ B. WING _____	04/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR ESTATES NSG & REHAB	**18300 SOUTH LAVERGNE COUNTRY CLUB HILLS, IL 60478**

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 contain the spread of COVID-19 as evidenced by failure to: monitor residents' temperatures every shift; promptly initiate contact/droplet isolation precautions for newly admitted residents or residents returning from the hospital; properly and consistently wear face masks; perform hand hygiene prior to donning personal protective equipment (PPE); and ensure social distancing among residents. These failures had the potential to affect all 141 residents in the facility who were at risk for contracting the [DIAGNOSES REDACTED]-Co2 virus during the 2020 global COVID-19 pandemic. Findings include: Interview of the Administrator on [DATE] at approximately 1pm revealed that there had been four COVID-19 positive residents, and 14 residents presently in contact/droplet isolation and under investigation for COVID-19. 1A. Observation on [DATE] at approximately 3pm revealed that Employee 1 (E1) was standing outside the elevator door on the fourth floor where residents were housed without a face mask. E1 was observed holding her face mask in her hand. B. During an observation on [DATE] at 2:30pm, Registered Nurse 1 (RN1) was observed standing across from the fourth floor nurses station in front of the elevator. RN1's face mask was positioned below his nose. One of the straps to the mask was broken and observed hanging next to RN1's face. C. On [DATE] at approximately 2:45pm, Nurse Aide 1 (NA1) was observed providing care to R1 who was in contact/droplet isolation. NA1 did not perform hand hygiene prior to donning an isolation gown and gloves outside R1's room. Furthermore, NA1's gloves were noted below the cuffs of the gown exposing her wrist area, rather than covering the cuff of the gown. D. Observation on ,[DATE] at approximately 4pm, revealed that NA3 was exiting R6's room following completion of incontinence care. Observation revealed that NA3's face mask was positioned below NA3's chin. When NA3 was questioned about the position of the face mask, NA3 stated, It was too hot. E. Observation on [DATE] at 11:14am, revealed that NA4 was cleaning R7 and R8's room. Observation revealed that NA4's face mask was hanging below NA4's chin. This observation was verified by the Assistant Administrator and the Chief Operating Officer (COO) who was present at the time of the observation. F. Observation on [DATE] at 11:30am, revealed E3 was not wearing a face mask while performing housekeeping duties on the third floor. This observation was verified by E1 and the COO who were in attendance during the observation. G. Observation on [DATE] at 12:15pm, revealed that E2 was observed in the Kitchenette area scraping dirty dishes. During the observation, E2's face mask was positioned below E2's chin. During this same observation, a resident refused his luncheon meal and it was returned to the kitchenette and placed on the same counter where the soiled dishes were being cleaned. The returned meal was wrapped and placed in the refrigerator by an unidentified aide. During the observation, the unidentified nurse aide was in the kitchenette with E2, and failed to inform E2 to cover her face. This observation was verified by the Administrator and the COO who was in attendance at the time of the observation. 2. Observation on [DATE] at 3:45pm, revealed that social distancing was not being maintained for four residents, R2, R3, R4 and R5 on the third floor. The observation revealed that R2 and R3 were seated next to each other in their wheelchairs, and R4 and R5 were seated next to each other in the Day Room. The residents were each approximately ,[DATE] inches apart from one another. NA2 was present during the observation, but did not ensure that residents maintained social distancing until directed by the Administrator. 3A. During an interview on [DATE] at 4:30pm, the Infection Control Preventionist (ICP) reported that residents who were newly admitted or who had returned to the facility from the hospital, were to have their temperatures monitored every shift and were to be placed in isolation for 14 days in accordance with CDC guidelines for management of COVID-19 pandemic. The ICP verified that nursing staff worked 8-hour shifts, from 7am - 3:30pm, 3pm - 11:30pm and 11pm - 7:30am. Review of R9's clinical record revealed that R9 had been admitted [DATE] following a three-day stay at the hospital. Review of R9's temperature log revealed that on ,[DATE], the day following her return from the hospital, R9's temperature was only monitored twice, at 9:07am and 1:03pm. R9's temperature was not taken again until ,[DATE] at 2:13am. B. Review of R10's clinical record revealed R10 had returned to the facility [DATE] following a 3-day stay at the hospital. Review of R10's temperature log revealed there were no recorded temperatures on [DATE], and only one recorded temperature on [DATE]. Furthermore, there was no documentation until [DATE] to show that R10 had been placed in contact/droplet isolation precautions. C. Review of R11's clinical record revealed R11 was admitted to the facility [DATE] following transfer to the hospital on [DATE]. Review of R11 temperature log for [DATE] revealed R11's temperature had been taken at 11:09am. The next recorded temperature was recorded as [DATE] at 6:48am, reflecting a 19.5- hour gap during which R11's temperature was not monitored. D. Review of R12's clinical record revealed that on [DATE] at 11pm, R12 had a temperature of 99F. R12's Progress Note dated [DATE] at 11:23 pm, reflected that R12's temperature had been noted to be 100.4F after the administration of Tylenol at 3:30pm. There was no indication provided to show what R12's temperature had been prior to the administration of Tylenol. Furthermore, the gap between the temperature taken on [DATE] at 11pm and the temperature taken [DATE] at 11:23pm reflected a 24-hour gap without R12's temperature being monitored. In addition, documentation on [DATE] at 11:23pm following the 24-hour gap without monitoring, reflected that R12 had complained of her body aching and having a headache, symptoms associated with COVID-19. R12 was transferred to the hospital on [DATE] at 7:50am. There were no temperatures on R12's temperature log following a single temperature recorded on [DATE] and a single temperature recorded on [DATE] when R12 was admitted . R12 returned to the facility [DATE] with a [DIAGNOSES REDACTED]. R12 returned to the facility on [DATE] at 6:28pm. However, there was no documentation in R12's clinical record to reflect that R12 had been placed in contact/droplet isolation precautions upon her return to the facility until [DATE] at 12:59pm, nearly 18 hours after her return. E. Review of R13's record revealed R13 had transferred to the hospital on [DATE] for fatigue, cough and weakness. While in the hospital, R13 was placed in isolation for a brief period on [DATE]. R13 returned to the facility on [DATE]. Review of R13's temperature log revealed a temporal arterial temperature, taken [DATE] at 8:45am, had been 99.3F. R13's temperature log revealed no additional temperatures had been recorded for the remainder of [DATE], and no temperatures were taken until [DATE] at 1:25am, a period of approximately 17 hours). R13 was discharged home to the community on [DATE], was returned to the hospital on [DATE] where she tested positive for COVID-19 and later expired. Review of the facility policy titled, [MEDICAL CONDITION] Revised dated [DATE], revealed the following direction in section C (c and d): Facility will adhere to key measures recommended by CDC and IDPH guidelines as appropriate q (every) shift checks, symptom monitoring for residents and staff. Review of the CMS memo QSO-,[DATE]-NH dated [DATE] by the Center for Clinical Standards and Quality/Quality, Safety and Oversight Group revealed the following directive: SUBJECT: Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED), revealed the following: Guidance: .Per CDC, prompt detection, triage and isolation of potentially infectious residents are essential to prevent unnecessary exposures among residents, healthcare personnel, and visitors at the facility. Therefore, facilities should continue to be vigilant in identifying any possible infected individuals. Review of the CMS memo QSO ,[DATE]-ALL, from Center for Clinical Standards and Quality/Quality, Safety & Oversight Group dated [DATE], revealed the following directive: SUBJECT: Prioritization of Survey Activities .For a resident with an undiagnosed respiratory infection: staff follow Standard, Contact, and Droplet Precautions (i.e, facemask, gloves, isolation gown) with eye protection when caring for a residents .For a resident with

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) known or suspected COVID-19: staff wear gloves, isolation gown, eye protection and an N95 or higher-level respirator if available. A facemask is an acceptable alternative if a respirator is not available. Additionally, if there are COVID-19 cases in the facility or sustained community transmission, staff implement universal use of facemasks while in the facility (based on availability). When COVID-19 is identified in the facility, staff wear all recommended PPE (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 of affected residents), regardless of symptoms Review of the facility's undated Employee Monitor Tool (COVID-19) indicated All employees must wear a mask with the nose pinched throughout their shift. This policy was verified as current with the Administrator on [DATE] at approximately 2pm. Review of the facility's Social Distancing Policy dated [DATE] indicated Social Distancing is a public health practice designed to limit the spread of infection by ensuring sufficient physical distance between individuals .Recommended distance is three to six feet. Review of the CDC guidance titled, How to Put On (Don) PPE Gear revealed the proper method was 1. Identify and gather the proper PPE to don .2. Perform hand hygiene using hand sanitizer. 3. Put on isolation gown .6. Perform hand hygiene before putting on gloves. Gloves should cover the cuff (wrist) of gown. In the section titled, Things Facilities Should Do Now of the same document revealed nursing home staff should Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infection. Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any with new symptoms. Review of the Infection Surveillance information attached to QSO-,[DATE]-NH specified that .at a minimum, vital signs are taken per shift .