STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146125	A. BUILDING _____ B. WING _____	10/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ASSISI HEALTHCARE OF CLARE OAKS	829 CARILLON DRIVE BARTLETT, IL 60103

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to supervise a resident at risk for aspiration while eating in her room. This applies to 1 of 1 residents (R2) reviewed for safety/supervision in a sample of 12. The findings include: Nutrition Care Plan, dated 9/16/20, shows R2 was to be provided set up/assistance/supervision/cueing as needed during meals. The care plan also shows R2 required monitoring for signs and symptoms of aspiration and, if aspiration symptoms occur, staff were to stop R2 from eating and notify the dietitian/physician/speech pathologist. On 09/28/20 at 12:53 PM, R2 was in her room, sitting in her chair, and had her lunch meal in front of her. R2 had mechanical soft meat on her plate and regular-textured, cooked vegetables. R2 was coughing while eating and drinking her lunch items. There were no staff in the room with R2 while she was coughing or eating her lunch. On 09/29/20 at 12:50 PM, R2 was sitting in her chair and some of her lunch food and beverage items were placed in front of R2 on a table. No staff were present in the room supervising R2. On 09/29/20 at 2:15 PM, V7 (Dietitian) stated R2 should be eating in the dining room for staff to supervise her while eating her meals due to her dysphagia and risk for aspiration. On 09/30/20 at 11:05 AM V8 (Speech Language Pathologist) stated R2 recently returned from the hospital with a [DIAGNOSES REDACTED]. V8 stated any resident with a mechanically altered diet should be supervised during their meals. Speech Therapy Plan of Care, start date 9/10/20, shows R2's [DIAGNOSES REDACTED]. The document shows R2 had a risk of trace aspiration had pre-oral/oral and pharyngeal swallowing impairments, and required a mechanically altered/ ground diet. Facility policy/procedure Room Tray Policy and Procedure, revised 6/2/20, shows, Procedure: 1. Meals will be served in resident's room. a. If they are to be assisted, supervised (including residents with altered diet texture and/or liquid consistency), or needs encouragement, residents may eat in the dining room with only one person per table. They will be six feet apart.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide perineal care in a manner that would prevent potential infection. This applies to 5 of 6 residents (R3, R14, R24, R27 and R36) reviewed for bowel and bladder in a sample of 12. The findings include: 1. On 09/29/20 at 2:12 PM, V12 and V14 (Both Certified Nursing Assistants/CNA) provided incontinence care to R3 who was wet with urine and had a bowel movement. V12 cleaned R3's perineum in a downward stroke however, V12 did not separate the labia to get it cleaned. 2. On 9/29/20 at 2:28 PM, V14 (CNA) assisted R24 to the toilet where R24 voided. After R24 finished voiding, V14 proceeded to clean R24's rectum and buttocks then he (V14) pulled R24's incontinence brief and pants back on without cleaning R36's genitals. 3. On 09/29/20 at 2:57 PM, V14 assisted R36 to the toilet where R36 voided. After R36 finished voiding, V14 proceeded to clean R36's rectum and buttocks then he (V14) pulled R36's incontinence brief and pants back on without cleaning R36's genitals. 4. On 09/29/20 at 3:30 PM, V14 and V15 (Both CNA) rendered incontinence care to R27 who was wet with urine and had a bowel movement. V14 cleaned R27's peri-area (scrotum and bilateral groins) with wet wipes. However, V14 did not clean R7's penis. R27 was turned to his left side for his rectum and buttocks to be cleaned. When V14 completed clean R27's lower backside, V14 proceeded to apply barrier cream and new incontinence brief. While on this process, R27 voided again and his thighs got wet. V15 wiped R27's thighs dry then they (V14 and V15) applied new incontinence brief, while R27's genitals remain uncleaned. 5. On 9/30/20 at 11:26 AM, V12 and V13 (Both CNA) provided incontinence care to R14 who was wet with urine. R14 was positioned in bed with both thighs somewhat drawn together. V13 cleaned R14's pubic area and outer labia with wet wipes in a downward stroke twice. However, V13 did not open R14's thighs to clean the groins as well as the inner labia then she (V13) proceeded to apply barrier cream and incontinence brief. On 09/30/20 at 12:05 PM, V2 (Unit Manager) stated that when staff provides incontinence care for female resident, the staff must clean the peri-area from front to back. The staff should separate the labia one wet wipe per area, groins, pubic area and the backside. For the male resident the staff must also wipe the peri-area from front to back, they (staff) should clean the penis, scrotum, groins and backside to avoid potential infection. R3's, R11's, R24's, R27, R36's most recent Minimum Data Sheet (MDS) showed that these residents required extensive assistance for toileting. Policy and Procedure for Perineal Care showed: The purpose of this procedures is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observed resident's skin condition. Procedure: For female resident: - Separate labia and wash area downward from front to back. - Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward [MEDICAL CONDITION]. For male resident: - Wash perineal area starting with urethra working outward. - Wash and rinse urethral area using a circular motion. - Continue to wash the perineal area including the penis, scrotum and inner thighs, do not re-use the same washcloth or water to clean the urethra.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to check the correct gastrostomy tube placement prior to medication administration via the tube. This applies to 1 of 1 resident (R8) observed for medication administration via gastrostomy tube. The findings include: On 09/29/2020 at 1:30 P.M., V6 (Registered Nurse) administered R8's medications via the gastrostomy tube. Prior to administration, V6 checked the bowel sounds, aspirated the gastrostomy tube but it was only air that came out from the tube and there was no gastric residual. V6 then pour 15 cc of water to the tube, then administered undiluted liquid suspension of Potassium Chloride 10 meq. 7.5 ml. medication into the gastrostomy tube, pour 5 cc of water into the tube and administered the crushed diluted 1 tablet of [MEDICATION NAME], then pour 5 cc of water into the tube and connected the tube to the gastric feeding. When asked what was the practice and policy for administration of medications via gastrostomy tube, V6 responded to check correct gastrostomy tube placement by auscultation and checking the gastric residual. V6 added that she did not checked the correct placement of gastrostomy tube and that she just checked for the bowel sounds. V6 also stated that she should have diluted the Potassium Chloride liquid of 7.5 ml to at least 4-8 ounces of water to avoid gastric irritation. On 9/29/2020 at 1:45 P.M., this concern was discussed with V1 (Administrator) and V3 (Unit Manager/ Infection Control Preventionist Nurse) regarding the failure of

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 0693 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) checking the correct placement of the gastric tube. V3 stated that correct placement of gastrostomy tube prior to medication administration should be done by doing auscultation and checking for gastric fluid residual. The revised facility's policy dated 3/2015 regarding medication administration thru the gastric tube showed to check correct placement prior to medication administration via auscultation and checking gastric fluid residual.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to follow standard infection control practices related to hand hygiene, the use of gloves and PPE (Personal Protection Equipment) during the provision of care. This applies to 5 of 6 residents (R3, R24, R27, R36 and R195) reviewed for infection control. The findings include: 1. On 9/29/20 at 2:12 PM, V12 and V14 (Both Certified Nursing Assistants/CNA) provided incontinence care to R3 who was wet with urine and had a bowel movement. V12 cleaned R3's frontal peri-area, while V14 cleaned R3's buttocks and rectal area. After cleaning R3's lower backside, V14 proceeded to apply barrier cream and new incontinence brief while wearing same soiled gloves. 2. On 9/29/20 at 2:28 PM, V14 (CNA) assisted R24 to the toilet where she voided. When R24 finished toileting, V14 wiped R24's rectum and buttocks. V14 then proceeded to put R24's brief and pants back in place, transferred R24 from the toilet to the wheelchair, while wearing same soiled gloves. 3 On 09/29/20 at 2:57 PM, V14 assisted R36 to the toilet where he voided. After R36 voided, V14 cleaned R36's rectum and buttocks, then he (V14) pulled R36's incontinence brief and pants back to its place and assisted R36 back to the wheelchair while wearing same soiled gloves. 4. On 09/29/20 at 3:30 PM, V14 and V15 (Both CNA) rendered incontinence care to R27 who was wet with urine and had a bowel movement. V14 and V15 cleaned R27, applied barrier cream, new incontinence brief, and pulled the pants back in place while wearing same soiled gloves. On 09/30/20 at 12:08 PM, V2 (Nurse Manager) stated that the staff must perform hand hygiene before and after providing care. In addition, the staff should also change gloves and do hand hygiene from dirty to clean task to avoid infection. Handwashing /Hand Hygiene Policy and Procedure The facility considers hand hygiene the primary means to prevent the spread of infection. Policy Interpretation and Implementation showed: Use an alcohol-based hand rub containing at least 62% alcohol or alternatively, soap and water for the following situations: - Before moving from a contaminated body site to a clean body site during resident care. - After contact with blood or body fluids. - After removing gloves. The use of gloves does not replace hand washing/ hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infection. 5. On 9/29/2020 at 11:30 A.M., R195 was in her room together with V4 (Registered Nurse) and V5 (Certified Nurse Assistant). They were all packing R195's personal belongings in preparation for discharge. There was a caution sign by R195's door entrance for contact and droplet precaution. During this observation, V3 (Unit Nurse Manager) was present. V3 stated that R195 was on isolation for contact and droplet precaution and on quarantine due to possible exposure to COVID-19. V5 was not wearing PPE (Personal Protective Equipment; gown, mask, gloves.) V3 stated that V5 should be wearing a PPE. The care plan dated 9/23/2020 showed that R195 was placed on COVID-19 Protocol and on contact and droplet precaution and on quarantine for 14 days from day of admission. The undated facility policy regarding COVID-19 infection control shows to place resident on quarantine, contact and droplet precaution for 14 days from the time of admission.