STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145607	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE OF PALOS HEIGHTS EAST	7850 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463

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 -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the unprecedented coronavirus global pandemic that resulted in the Presidential declaration of a State of National Emergency dated 3/13/20, the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) Memo QSO-20-14-NH revised on 3/13/20, Nursing Home guidance from the Centers for Disease Control (CDC), and observation, interview, and record review, the facility failed to ensure that staff: 1) used full personal protective equipment (PPE) every time staff entered an isolation room including serving meals; 2) used N95 respirator masks properly by not using a cloth mask underneath; 3) refrained from touching the front part of the mask; and, 3) had readily available PPE for use (face shield, masks, gowns) as needed to care for persons under investigation (PUI) and with orders for isolation. This failure had the potential to expose six non-isolation residents to the COVID-19 virus under the care of the staff. The IJ began on 5/13/20 at 12pm, when Nursing Assistant (NA)1 who was wearing a cloth mask under the N95 respirator, entered R1's room, an isolation room, without wearing a gown or gloves to serve the lunch tray, and when interviewed, kept on adjusting the N95 mask by touching the front part of the mask. In addition, there was no adequate PPE set up that was readily available for use in three isolation rooms (R1, R2 and R3). The facility had six current staff and 16 residents who tested positive for COVID-19. The Administrator was notified of the Immediate Jeopardy on 5/14/20 at 2:52pm. According to https://www.nih.gov/news-events/news-releases/new-coronavirus-stable-hours-surfaces National Institute of Health (NIH) Tuesday, March 17, 2020 New coronavirus stable for hours on surfaces [DIAGNOSES REDACTED]-CoV-2 stability similar to original [DIAGNOSES REDACTED] virus. [MEDICAL CONDITION] that causes coronavirus disease 2019 (COVID-19) is stable for several hours to days in aerosols and on surfaces, according to a new study from National Institutes of Health, CDC, UCLA and Princeton University scientists in The New England Journal of Medicine. The scientists found that severe acute respiratory syndrome coronavirus 2 ([DIAGNOSES REDACTED]-CoV-2) was detectable in aerosols for up to three hours, up to four hours on [MEDICATION NAME], up to 24 hours on cardboard and up to two to three days on plastic and stainless steel. The results provide key information about the stability of [DIAGNOSES REDACTED]-CoV-2, which causes COVID-19 disease, and suggests that people may acquire [MEDICAL CONDITION] through the air and after touching contaminated objects. The study information was widely shared during the past two weeks after the researchers placed the contents on a preprint server to quickly share their data with colleagues. The NIH study attempted to [MEDICAL CONDITION] being deposited from an infected person onto everyday surfaces in a household or hospital setting, such as through coughing or touching objects. The scientists then investigated how long [MEDICAL CONDITION] remained infectious on these surfaces. The scientists highlighted additional observations from their study: If the viability of the two coronaviruses is similar, why is [DIAGNOSES REDACTED]-CoV-2 resulting in more cases? Emerging evidence suggests that people infected with [DIAGNOSES REDACTED]-CoV-2 might be spreading virus without recognizing, or prior to recognizing, symptoms. This would make disease control measures that were effective against [DIAGNOSES REDACTED]-CoV-1 less effective against its successor. In contrast to [DIAGNOSES REDACTED]-CoV-1, most secondary cases of virus transmission of [DIAGNOSES REDACTED]-CoV-2 appear to be occurring in community settings rather than healthcare settings. However, healthcare settings are also vulnerable to the introduction and spread of [DIAGNOSES REDACTED]-CoV-2, and the stability of [DIAGNOSES REDACTED]-CoV-2 in aerosols and on surfaces likely contributes to transmission of [MEDICAL CONDITION] in healthcare settings. According to: https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html .To prevent infectious disease transmission, elimination (physically removing the hazard) and substitution (replacing the hazard) are not typically options for healthcare settings. However, exposures to transmissible respiratory pathogens in healthcare facilities can often be reduced or possibly avoided through engineering and administrative controls and PPE. Prompt detection and effective triage and isolation of potentially infectious patients are essential to prevent unnecessary exposures among patients, healthcare personnel (HCP), and visitors at the facility. N95 respirators are the PPE most often used to control exposures to infections transmitted via the airborne route, though their effectiveness is highly dependent upon proper fit and use. The optimal way to prevent airborne transmission is to use a combination of interventions from across the hierarchy of controls, not just PPE alone. Applying a combination of controls can provide an additional degree of protection, even if one intervention fails or is not available . According to https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html updated on April 15, 2020 revealed: Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at the highest risk of being affected by COVID-19. If infected with [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] that causes COVID-19, residents are at increased risk of serious illness. COVID-19 cases have now been reported in all 50 states and DC; with many areas having wide-spread community transmission. Given the high risk of spread once COVID-19 enters a nursing home, facilities must take immediate action to protect residents, families, and healthcare personnel (HCP) from severe infections, hospitalization s, and death. Visitors and HCP continue to be sources of introduction of COVID-19 into nursing homes. To protect the vulnerable nursing home population, aggressive efforts toward visitor restrictions and implementing sick leave policies for ill HCP, and actively checking every person entering a facility for fever and symptoms of illness continue to be recommended . Findings include: During the entrance interview on 5/13/20 at 11am, the Administrator confirmed the facility had confirmed cases of residents with COVID-19 in the designated unit called COVID-19 AIRBORNE ISOLATION UNIT (CAIU) on second floor and residents who are considered PUIs on the third floor. During the tour and review of the resident list, the facility had 16 positive cases in the designated CAIU unit and three PUIs in the non-COVID-19 floor of the facility. During the tour of the non-COVID unit on 5/13/20 at 12pm, revealed that there were three residents' rooms (room [ROOM NUMBER], room [ROOM NUMBER] and room [ROOM NUMBER]) that had STOP SIGN SEE NURSE BEFORE ENTERING posted on the door. An isolation set-up was hanging on room [ROOM NUMBER] (R3's room) door. The isolation set-up had boxes of gloves but no other PPE. In the hallway across from room [ROOM NUMBER](R1's room), in between rooms [ROOM NUMBERS], a plastic bag containing a yellow gown was hanging by the handrail. Hanging right outside room [ROOM NUMBER] (R2's room) by the hand rail was a blue gown. At approximately 12:20pm, NA1 entered room [ROOM NUMBER](R1's room) with a lunch tray. NA1 was wearing an N95 mask but underneath the mask was a cloth mask. NA1 was not wearing a gown or gloves. NA1 was heard telling R1 that she would come back later to turn off the call light since she was not wearing a gown. NA1 brought R1's lunch tray (non-disposable utensils) back to the cart when R1 indicated he did not want to eat. Then NA1 took the yellow gown out of the plastic bag that was hanging across from R1's room. NA1 donned gown and gloves and entered R1's room. After a few minutes, NA1 came out of R1's room and doffed the gown and put it back in the plastic bag and left it hanging across from R1's room. When asked, why R1 was on isolation, NA1 stated the resident was exposed to his roommate who was moved to the COVID unit. When asked what PPE should be worn when entering the room, NA1 stated that she should wear a mask, gown and gloves when entering the room. When asked why she was wearing a cloth mask underneath the N95mask, NA1 did not answer. At this time, the Unit Manager joined the interview. When asked about the cloth mask, NA1 confirmed that the cloth mask underneath the N95 mask was her personal mask. During this interview, NA1 was observed adjusting her N95 mask by touching the front part of the mask. The surveyor intervened and told

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145607	A. BUILDING _____ B. WING _____	**05/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE OF PALOS HEIGHTS EAST	**7850 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463**

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) NA1 not to touch the front part of the mask. NA1 sanitized her hands after prompting from the Unit Manager. The Unit Manger confirmed that R1, R2 and R3 were considered PUIs and were placed on isolation. The Unit Manager also confirmed that the isolation rooms were not set up with available PPE for staff to use in case they needed to enter the room. During an interview with the Director of Nursing (DON) on 5/13/2020 at 2:30pm, the DON was asked about required PPE set-up and use for airborne isolations. The DON stated that PUIs were placed on airborne isolation, and staff were expected to wear the same PPE as though they were caring for COVID-19 residents which included N95 masks, gowns, gloves and face shields. The DON also clarified that the COVID unit required the use of shoes protectors. Review of the Daily Deployment Sheet dated 5/13/19 revealed there were seven residents (R1, R4, R5, R6, R7, R8 and R9) assigned under NA1's care from 6am to 2pm. Except for R1, the six residents under NA1's care were not on isolation precautions. Review of R1's physician's orders [REDACTED]. Review of R1's progress notes dated 5/15/20 revealed Writer spoke to patient's sister-in-law (name of sister in law) about the room move since patient is positive for Covid-19. Patient and family agreeable to move. Review of R10's (R1's roommate) electronic record revealed Effective Date: 5/12/2020 11:36 (Name of Nurse Practitioner (NP), NP notified of Covid19 positive test results .New room # and phone number for the son provided .5/12/2020 15:22 Patient transferred to 2nd floor . (COVID unit) in stable condition with all medications and belongings. Report given to receiving nurse. Review of R2's POS revealed airborne isolation dated 5/12/20 Review of R3's electronic record dated 5/12/20 revealed Np (for name of MD) updated of patients status-elevated temp and about roommate who tested positive for Covid19. Patient started on Z-pack (an antibiotic), Zinc (supplement) daily and Vit C 500 (Vitamin supplement). Orders carried on, first dose of Z-pack given .Effective Date 5/13/20 11:26 Patient notified of positive Covid 19 test results and that will have to transfer to second floor for airborne isolation. Voiced understanding .Patient already started yesterday on ABT (antibiotic) . Review of R6's COVID-19 test result done on 5/5/20 and reported on 5/11/20 revealed a negative result. Review of R4's COVID-19 test result that was done on 5/12/20 and reported on 5/15/20 revealed a positive result. R4's POS dated 5/15/20 revealed an order for [REDACTED]. R7's [DIAGNOSES REDACTED]. The Administrator was notified that the immediacy was removed as of 5/14/20 when the acceptable removal plan was accepted and after the surveyor verified that the removal plan was implemented. Verification of the removal plan on 5/19/20 included: 1. Observation of staff wearing N95 and facemasks properly throughout the facility. 2. Observation of isolation set-up and availability of PPE in the isolation rooms. 3. Observed staff donning and doffing PPE when entering and leaving isolation rooms. 4. Review of in-service dated 5/13/20, 5/14/20, 5/15/20, 5/16/20, 5/17/20, and 5/18/20 provided to all staff regarding the use of N95, Donning/Doffing PPE, and PPE Usage Guide. 5. The specified employee was taken off from schedule for monitoring for 14 days 6. Interviews were conducted to assess staff knowledge of the PPE usage. 7. Review of the facility audits on proper use of PPE and availability of PPE supplies After removal of the Immediacy, the non-compliance remained at the level of no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy until sustained compliance is verified.