STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145758	A. BUILDING _____ B. WING _____	**05/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE GLENWOOD	**19330 SOUTH COTTAGE GROVE GLENWOOD, IL 60425**

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 the unprecedented coronavirus global pandemic that resulted in the Presidential declaration of a State of National Emergency declared 3/13/20, the Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) Memo QSO-20-14-NH (revised 3/13/20), Nursing Home guidance from the Centers for Disease Control and Prevention (CDC), and observation, interview and record review, the facility failed to ensure that visitor screening was performed, hand hygiene for resident and staff was performed during dining, and social distancing was maintained in three of four units in the facility. This had the potential to affect all 106 residents in the facility. Findings include: Observation upon entry to the facility on [DATE] at 10am, revealed that the facility failed to conduct a visitor screening when this surveyor entered the facility. This surveyor asked if a visitor's screening was supposed to have been conducted for all visitors to the facility, and the receptionist answered, Yes. This surveyor asked if visitors to the facility were supposed to have their temperature taken as part of the screening and the Receptionist stated Yes. After being prompted, the Receptionist proceeded to take the surveyor's temperature. The surveyor asked if there was anything else that needed to be completed for visitors entering the facility. The Receptionist pointed to a questionnaire for the surveyor to complete. Review of the procedures titled COVID - 19 indicated, Visitor Screening 1. All allowed visitors will be required to check in at the reception desk or nurse designee. 2. Hand Sanitizer will be available, and visitors will be directed to utilize upon entering and leaving the facility 3. Visitors Log has been updated to include documentation that these requirements are met. Make Sure Visitors Are Signing In/Out and checking off on these questions. Review of a letter sent to families at the facility dated 3/16/20 stated, We require all employees, and approved visitors to answer a few simple health screening question and undergo a temperature check upon entering the facility . During the entrance conference, the Administrator was questioned about the screening process. The Administrator stated that everyone who enters the facility is to be screened. Observation on 5/6/20 at 10:25am, revealed that the Human Resource staff member was not wearing a face mask while communicating with the Receptionist at the Front Desk. The staff member then entered the Conference Room where the Administrator was meeting with the surveyor. The Administrator stated that the staff member should have been wearing a face mask. On 5/6/20 at approximately 10:30am, Nurse Aide 1 (NA1) revealed that NA1 entered the facility and was observed standing at the Receptionist Desk. NA1 was wearing a face mask which was positioned below his nose. Observation revealed that NA1 lowered the face mask below his mouth each time he talked to the Receptionist. Observation further revealed that hand hygiene was not performed each time he adjusted the face mask. This observation was brought to the attention of the Administrator who was with the surveyor at the time of the observation. The Administrator stated that, face masks are to cover the nose and the mouth and hand hygiene should have been done. During a tour of the facility on 5/6/20 at 12:20pm, observation with the MDS Coordinator revealed the following: Observation on 5/6/20 at 12:20pm, revealed that R1 was seated in a wheelchair at the entrance to the room. Observation revealed that R1's face mask was observed below her nose resting on her chin. Observation revealed that Licensed Practical Nurse 1 (LPN1) came into the room to adjust R1's mask. Upon completion of the task, LPN1 went directly into R2's to assist the resident. LPN failed to perform hand hygiene prior to assisting R1 and R2. Observation on 5/6/20 at 12:25pm, revealed that NA2 removed a luncheon tray from the dining cart and proceeded to pass luncheon trays to rooms: 203, 204, 205, 206, 207, and 209. NA2 was observed to go into each of the rooms listed and placed the dining trays on the over bed tables, and then exited each of the rooms without performing hand hygiene. Observation revealed that while NA2 was in R1's room, NA2 pulled the resident wheelchair away from the entrance to the door and repositioned NA2 next to the over bed table. Hand hygiene was not performed prior to getting another luncheon tray from the dining cart. Observation at approximately 12:30pm, revealed that LPN1 entered R3's room to assist R3, exited R3's room and entered R4's room to provide assistance to R4. Observation revealed that LPN1 did not perform hand hygiene prior to entering and exiting each room. Observation on 5/6/20 at 12:35pm, revealed that NA3 entered the C Wing Unit to pass trays. NA3 went directly to the dining cart to remove a luncheon tray without performing hand hygiene. NA3 then removed a dining tray from the dining cart and went into R5's room with the dining tray. Observation revealed that NA3 repositioned R5's chair in order to provide better access to the luncheon meal. NA3 then positioned R5's dining utensils and exited the room without performing hand hygiene. Observation on 5/6/20 at approximately 12:40pm revealed that LPN2 was wearing gloves while passing luncheon trays on the C Unit. LPN2 entered R6's room to pass a tray. LPN2 proceeded to deliver luncheon trays to two different residents in the same room. LPN2 failed to remove her gloves between residents and to perform hand hygiene. Observation revealed that E1 was observed removing a luncheon tray from the dining cart on 5/6/20 at approximately 12:45pm. E1 then walked down the hall to deliver the tray to the resident, however couldn't locate the correct room. E1 then walked into another resident's room with the tray to ask another Nursing Assistant about the location of the resident. E1 then proceeded to deliver the luncheon tray to R7's room. Upon exit from R7's room, E1 failed to perform hand hygiene. Observation on 5/6/20 at approximately 12:50pm revealed that E1 entered R8's room and placed the luncheon tray on R8's bed. E1 then proceeded to get another luncheon tray from the cart and delivered the tray to R9's room. Hand hygiene was not performed prior to or after the delivery of the trays. Observation on 5/6/20 at approximately 12:57pm revealed that R9 requested a spoon from a staff member, however, R10 offered R9 her spoon. R9 went into R10's room to use R10's spoon, returned the spoon to R10, and sat next to her to visit. Observation revealed that the two residents were approximately five inches from each other while visiting and social distancing was not maintained. Although nursing assistants were in the hall, social distancing was not reinforced by the staff. Observation during the noon meal on Units A, B and C revealed that hand hygiene was not performed on all residents prior to receiving their luncheon meal. During an interview, the Quality Assurance Coordinator who was passing trays on Unit A, was asked about the hand hygiene policy related to residents prior to meal time. The QA Coordinator stated the resident's hands were not washed and she was unsure of a policy related to hand hygiene prior to meal times. During an interview on 5/6/20 at approximately 1:10pm, LPN2 was asked about hand hygiene prior to meal time for all residents. LPN2 stated We don't have a procedure to wash the resident's hands prior to meal time. Review of the Hand Washing Policy dated 9/23/15, related to Procedure revealed the following direction for performing hand hygiene: 5. Before and after direct contact with residents. D. after removing gloves . Review of Hand Hygiene, Point to remember indicated, This facility considers hand hygiene the primary means to prevent the spread of infections. All staff will properly wash hands after direct contact with contaminated substance, after direct resident care and as instructed.

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.