STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	C 07/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

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S 000	Initial Comments Covid-19 Focused Infection Control Survey Complaint Investigation 2091872/IL120909	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 2) Section 330.1130 Communicable Disease Policies a) The facility shall comply with the Control of Communicable Diseases Code (77 Ill. Adm. Code 690). These regulations were NOT MET as evidenced by: Based on observation and interview, the facility failed to properly contain the spread of COVID-19 by not following current Centers for Disease Control (CDC) guidelines for health care settings by not wearing personal protective equipment (PPE) as required and by failing to screen visitors and facility staff prior to or upon entrance in to the facility. This failure has the potential to affect the three residents (R1, R2, and R3) reviewed for infection control. Findings include: 7/1/20 at 1:15 PM, surveyor entered the vestibule of the facility's housing unit. V5 (Certified Nurse's Aide) came to the door with just a mask on her face and let surveyor in the door. V5 did not	S9999		

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S9999	Continued From page 1	S9999		

screen surveyor for COVID-19 and did not take surveyor's temperature. Asked if personal protective equipment was necessary to enter or were available before entering, V5 stated, "If you want but your mask is fine." V3 (Registered Nurse) approached surveyor with only mask on and asked if she could help surveyor with anything and went back down the corridor towards resident rooms. V4 (Certified Nurse's Aide) was observed walking in and out of rooms, not wearing full Personal Protective Equipment (PPE) but only a mask and gloves. Down the two resident corridors there were no isolation bins to house any PPE or signage to warn of any isolation precautions nor to stop and wear PPE prior to entering any of the rooms.

7/1/20 at 1:25 PM, V1 (Administrator) came to the unit and requested to meet in an alternate housing unit in another building. V1 stated that there were 11 current people isolated for COVID-19 with all seven residents who were in their isolation unit where surveyor first entered. V1 also mentioned that the other four were housed in another unit but was not considered their COVID unit as the four residents were waiting for second negative test outcomes. Surveyor asked V1 whether anyone entering the COVID unit (house which surveyor first entered) is required to don full PPE such as mask, face shield, gloves and gown and V1 stated, "Yes all staff should be wearing them." Surveyor informed V1 that there were no staff observed by surveyor to be wearing any brightly colored yellow gowns or face shields as shown by V1.

V2 (Director of Nurses) accompanied surveyor back to the COVID unit and upon entering the vestibule, there were masks, gloves and face shields but no gowns in their PPE container. V2

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used her phone and called the other unit for staff to bring over gowns for V2 and surveyor to wear upon entering. Upon entering, surveyor again was not asked any questions, forms to fill out, or temperature taken. V3 (RN) on the unit was asked if she took temps of visitors and staff prior to entering the unit; V3 stated, "Yes, I do it at the beginning of the shift and the other nurse on each shift takes everyone's temperature." Asked to provide their temperature logs and forms to confirm this practice, V3 was unable to comply with request. V3 stated, "I don't save them and I don't know who keeps them." V2 was asked about any forms but was unable to provide any and stated, "I will look into it."

7/01/20 at 2:10 PM ,V4 (Certified Nurse's Aide) was asked about the PPE that he was now wearing but was absent earlier. V4 stated, "We're supposed to be wearing all of this (gown, mask, face shield, gloves) because everyone here is on COVID isolation." Asked when he was given the PPE's to wear, V4 stated, "Well they just handed them out about 15 minutes ago and told us to make sure we were wearing them." Surveyor asked if they always wear the PPE and V4 paused and said, "Well not really." V3 was then asked about the COVID infection protocols and stated, "We should all be wearing full PPE and not just masks." Asked about where the PPE is located as there were none in the entrance vestibule and V3 stated, "Well they're handed out to all the staff. I can't tell you if they wear them but they should be."

(B)

(Violation 2 of 2)

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S9999	Continued From page 3 Section 330.4240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) These regulations were NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to follow their policy for abuse and neglect of residents by involuntarily secluding a resident from other residents on the unit. This failure affected one resident (R1) reviewed for abuse. Findings include: R1 is a 62 year old hospice resident with diagnoses of dementia, developmental delay, diabetes, and hypertension. 7/1/20 at 2:00pm, surveyor tried to enter R1's locked room. At 2:20 PM, V4 (Certified Nurse's Aide) asked who surveyor was looking for, took keys from his pocket and unlocked the door for surveyor to enter R1's room. Inside the room on the right hand corner of the room, R1 lay under a blanket with R1 clutching a stuffed animal toy against his chest. Surveyor asked R1 if he was okay but R1 was unable to respond and appeared frightened and became tearful. Surveyor asked V4 who locked the door; V4 stated, "We do because (R1) can't get up to lock it because he can't walk." Surveyor asked V4 why the door was	S9999		

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locked; V4 stated, "We always lock it because there's one resident on the floor that walks around and we don't want her to walk in there." Asked whether any other resident rooms were locked off and V4 stated, "No just R1's." Asked how long R1's room was being locked and V4 stated, "We've been locking (R1's) door up since he's been here and I never thought it was a problem." Asked if R1 was able to get up to lock or unlock his door; V4 stated, "No, he can't walk and he's kind of confused."

Surveyor approached V2 (Director of Nursing) and asked about R1's room being locked. V2 stated, "I didn't know they locked his door. This shouldn't be locked at all. I guess it would be a fire hazard." Surveyor asked V2 what she would do about R1's room being locked by staff from inside his room. V2 stated, "I'll let the administrator know about it right away but I don't think we should be locking him up in there." Surveyor asked V2 if locking R1 up in his room was a facility policy or doctor's order, V2 stated, "I checked and no there is no policy I can find that instructs staff to lock R1's room or any resident room and it's definitely not a doctor's order." Surveyor asked V2 about the types of abuse and V2 was only able to name three types of abuse. V2 stated, "I'm sorry, I should know this but I had a card telling me the types and I don't have it with me."

Interview with V3 (Registered Nurse) at 2:45 PM stated, "We lock R1's door because there's ambulatory residents here that like to go into rooms." Surveyor asked why R1's room was the only room locked by staff. V3 stated, "Well we lock all the resident doors to keep them inside." Asked about freedom of movement for residents and about fire hazards risk; V3 stated, "Well we

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S9999	Continued From page 5 check on them regularly." At 2:55 PM, Surveyor tried to open R1's door and it appeared to have been locked from the inside. Surveyor was able to open other resident room doors on the unit which V3 stated were all supposed to be locked. During interview with V1 (Administrator) at 3:05 PM, V1 stated, "I talked to maintenance and I'm told those doors have been able to be locked for as long as he remembered. I checked with our home office and we're evaluating it now." Surveyor asked V1 whether there was going to be any change in practice in locking R1's door or any other resident room door. V1 stated, "Like I said, we're evaluating it now." Facility's undated policy titled "Abuse and Neglect of Residents" documents: Abuse, neglect, or misconduct occurs when an individual associate willfully or intentionally seeks to physically or emotionally harm a resident. Any action where proper policy or professional practice was intentionally disregarded and the associate could reasonably foresee the probably physical or emotional harm that his or her actions could cause the resident, is also considered abuse, neglect, or misconduct. Abuse, neglect or misconduct in care does not constitute negative outcomes where judgement, reasonable caution and care or adherence to policy and practice standards were applied, or if a resident was responsible for causing the negative outcome to occur via their own actions or non-actions. (No Violation Issued)	S9999		