Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002364	A. BUILDING: _____ B. WING _____	11/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE DANVILLE	1701 NORTH BOWMAN DANVILLE, IL 61832

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments COVID 19 Focused Infection Control Survey Complaint Investigations #2068179/IL127775, #2068105/IL127692, #2068527/IL128153, and #2068087/IL127673	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 3 300.1010 h) 300.1210 b) 300.3240 a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidenced by: Based on interview and record review, the facility failed to notify a physician of abnormal laboratory results for one of five residents (R1) reviewed for change in condition on the sample of 53. This failure resulted in R1's deterioration in mental, respiratory, and cardiac status, resulting in R1's death on 10/13/2020. R1 died within 17 days of the unreported urine culture results, and within 7 days of R1's unreported abnormal additional laboratory results. Findings include: R1's Hospital Records, dated 8/26/2020, document R1's "problem list" including Pneumonia and a history of complicated urinary tract infection. These records document R1's diagnoses including Resistance to multiple antibiotics, Hypokalemia and Tracheostomy (Trach), and that R1 has a chronic urinary catheter. R1's Progress Notes, dated 9/25/2020 at 1:38pm, document R1 received an order to start Levaquin (Antibiotic) 500mg (milligrams) one tablet daily for 10 days for secretions and possible Urinary Tract Infection (UTI). R1's Urinalysis results, dated 9/25/2020, document a handwritten note "await c+s (culture	S9999		

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S9999	Continued From page 2 and sensitivity)" with the following abnormal results with normal range in parentheses: Appearance: Turbid (Clear) Leukocyte: Moderate (Negative) Protein: 100 (Negative) Nitrite: Positive (Negative) Blood: Trace (Negative) W.B.C (White Blood Cells): 5-10 (Negative) R.B.C (Red Blood Cells): 0-1 (Negative) Bacteria: 2+ (Negative) R1's Urine Culture results, with reported date of 9/27/2020 at 9:04pm, document R1's urine contained greater than 100,000 Pseudomonas Aeruginosa that was resistant to the Levaquin (Levofloxacin) antibiotic initially ordered for R1 on 9/25/2020. There is no documentation in R1's medical records of V29, R1's Hospice Physician, or hospice being notified of the urine culture results. There were no orders to change R1's antibiotic to one the Pseudomonas Aeruginosa was susceptible to. R1's laboratory test sheets, dated received on 10/5/2020, and a reported date of 10/7/2020 document results including the following "Abnormal High" results with normal range in parentheses: Blood Urea Nitrogen (BUN): 51mg/DL (milligrams per deciliter) (2-34) Creatinine: 2.4mg/DL (0.4-1.6) Potassium: "unable to obtain result" Ammonia, Plasma: 342 UG/DL (micrograms per deciliter) R1's Medical Records do not document V29 or	S9999		

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hospice notification of R1's laboratory results from 10/5/2020.

R1's Progress Notes dated below document the following:

9/30/2020 7:26pm - R1 restless
10/1/2020 6:14am - R1 "with facial grimacing, crying."
10/3/2020 3:51am - R1 "very restless."
10/3/2020 4:31am - R1 with facial grimacing with restlessness urinary catheter with straw color urine.
10/3/2020 12:48pm - R1 alert/responding to voices.
10/4/2020 3:07pm - R1 had "couple of twitches earlier this morning." At 2:30pm, R1 appeared to have a seizure lasting approximately 10 seconds.
10/5/2020 2:42pm - R1 "not responsive." There is no documentation of physician or family notification.
10/5/2020 6:28am - R1 had "intermittent twitches for about 30 minutes." No family notification documented.
10/6/2020 3:29am - R1 with "labored breathing" Respirations 26, intermittent periods of 4-6 second apnea. SpO2 89-90%. 4:27am R1's temperature at 100.9 degrees Fahrenheit.
4:29am R1 with labored breathing.
10/7/2020 2:07am - R1 "very restless. Labored breathing."
10/7/2020 9:59pm - low blood pressure
10/8/2020 12:54am - Fever 100.1. There is no physician or family notification documented.
12:55am R1 "very restless" 3:51am R1 "facial grimacing, restless." 11:01pm, R1 "is sleeping most of the time but awakens when being cared for. Has copious amount of white frothy phlegm coming out from the trach."
10/10/2020 2:27am - "very restless with facial

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grimacing"
10/10/2020 4:18am - R1 "continues to be restless."
10/11/2020 12:11am - "facial grimacing with care, very restless."
10/13/2020 3:41am - "found (R1) lethargic at 3am, checked for heart rate was 20/min (per minute), no respirations noted. Went back in to recheck pulse. "Heartbeat not applicable."

On 10/28/2020 at 11:35am, V32, Regional Nurse Manager for hospice, stated the facility should be contacting hospice with laboratory results and changes in condition for R1. V32 stated there is no documentation the facility notified hospice of R1's laboratory results for the urinalysis, urine culture, or the additional lab results dated 10/5/2020. V32 stated the list the facility provided to hospice did not include R1's Potassium supplement medication, so that is why hospice did not order the Potassium medication to continue upon R1's admission in to the hospice program. V32 stated hospice would have continued the Potassium medication if hospice would have been given R1's accurate current medication list. V32 stated R1 was started on Levaquin for sediment in R1's urine while waiting for the culture results. V32 stated the facility never notified hospice of R1's urine culture results, and if they would have, R1's antibiotic would have been changed to something that the organism was susceptible to. V32 stated V33, R1's family, had reported concerns of being "very uneasy" related to the facility's care of R1. V32 stated hospice began seeing R1, who remained very stable, and R1's passing was not expected at the time of R1's decline and death.

On 10/28/2020 at 1:15pm, V28, Nurse Practitioner (NP) for hospice, stated V28 was not

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S9999	Continued From page 5 notified of R1's urine culture results, which indicated R1 needed an appropriate antibiotic prescribed that the organism in R1's urine was susceptible to. V28 stated if the facility would have notified V28 of the urine culture results, V28 would have provided orders for R1. V28 stated V28 and/or hospice should have been notified of R1's abnormal laboratory results from 10/5/2020. V28 stated R1 should have had R1's Potassium medication continued, and that would not have been discontinued by V28 or hospice. V28 stated the laboratory report documenting R1's Potassium level as unable to be obtained tells V28 R1's Potassium level was unable to be detected in R1's blood, which would correlate to "minimal" Potassium in R1's blood due to diuretic use and not receiving a Potassium medication to supplement what was being lost with R1's use of diuretic medication. V28 stated in V28's professional opinion, R1's untreated UTI due to the facility's failure to notify the physician, progressed to sepsis, which along with R1's very high ammonia level and potassium lab results of unobtainable that went unreported, contributed to R1's deterioration and death. (AA) 2 of 3 300.1210 b) 300.1210 d)2) 300.3240 a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest	S9999		

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practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
2) All treatments and procedures shall be administered as ordered by the physician.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These regulations are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to properly provide tracheostomy care as ordered by the physician for two of two residents (R1, R6) reviewed for tracheostomy care in the sample of 53. This failure resulted in R1 and R6's deterioration in respiratory status. R1 and R6 required multiple Emergency Room visits due to R1 and R6's tracheostomies being plugged, resulting in restricted air flow and difficulty breathing.

Findings include:

The facility's Tracheostomy Care policy, dated 8/20/18, documents the policy is used to remove secretions from the tracheo-bronchial tree. To "maintain an unobstructed airway for the maintenance of ventilation." This policy documents to explain the procedure to the

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resident, prepare the tracheostomy dressing tray and remove the non-disposable inner cannula and place in hydrogen peroxide. Clean thoroughly and rinse well. Remove gloves, discard and wash hands. Suction before replacing inner cannula." This policy documents to turn on suction machine and don sterile gloves. "Using sterile hand, with vent or y-connector open insert catheter 4-5 inches to aspirate trachea, or 8-10 inches to suction bronchi." Turn head to suction bronchi as appropriate. "For tenacious secretions 1-3 cc (cubic centimeters) of sterile saline may be instilled via syringe, with MD (medical doctor) approval." Sterile saline "will thin and loosen dry thickened secretions for easier removal." Continue suctioning until tracheo-bronchial tree is clear. Assess by listening for clear breathing by ear and by stethoscope. Clean outside of outer cannula as needed before replacing inner cannula. This policy documents to document the procedure in the clinical record and/or sign on electronic treatment record as appropriate. "Emergency Care: If outer tube comes out, stay with resident and summon assistance. A rubber tipped hemostat maybe used to maintain opening."

1.) R6's Admission Record dated, 10/26/2020, documents R6's diagnoses including Neoplasm of Larynx, Chronic Obstructive Pulmonary Disease (COPD), Dyspnea and Tracheostomy (trach).

R6's Progress Notes dated 8/31/2020 document R6 complains of needing to have trach suctioned often and is alert and oriented. R6's Progress Notes dated 9/2/2020 document R6 is "anxious about the care of (R6's) tracheostomy." R6's Progress notes, dated 9/17/2020 at 7:29am, R6 complained of shortness of breath with oxygen

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S9999	Continued From page 8 saturation 90%. R6 requested to be sent to the emergency room. R6's Progress Notes, dated 9/22/2020 at 2:00pm by V31, R6's Nurse Practitioner (NP), document staff are to provide frequent suctioning and monitor oxygen saturation. Notes dated 9/23/2020 at 3:19am - R6 requesting to be sent to the emergency room and complaining of left flank, chest, left arm pain, shortness of breath, chills then sweating. R6 stated R6 "feels like (R6) has something stuck in (R6's) lungs." Notes dated 9/28/2020 at 4:11am - R6 taking the inner cannula out of R6's trach and wanting it cleaned every 2 hours. Notes dated 10/1/2020 at 10:00pm, R6 was transferred out to the emergency room after R6 removed the inner cannula and when V34, Registered Nurse, attempted to reinsert, there was an obstruction so R6 was sent to the hospital. R6 complained of shortness of breath at this time. Notes dated 10/12/2020 at 2:30pm, R6 complained of pain to the lower abdomen. R6's oxygen saturation was 82% on room air, R6 refused to put oxygen on. R6 had removed R6's inner cannula which was cleaned. R6's inner cannula met resistance and was unable to be re-inserted, and R6 requested to be sent to the emergency room. Notes dated 10/12/2020 at 2:01pm, documents V3, Assistant Director of Nursing (ADON), was "called into (R6's) room by another nurse who found R6 unresponsive." This note documents R6 had had "pulled entire tracheostomy tube out and was bleeding from the site. (R6) was gasping for air." V3 attempted to replace tracheostomy tube but the airway was blocked. V3 held trach tube halfway in. R6 was sent to the emergency room. Notes dated 10/21/2020 at 1:35pm, R6 requested to be sent to the emergency room for "COPD." R6's After Visit Summary (AVS) for multiple emergency room visits document discharge	S9999		

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S9999	Continued From page 9 instructions as well as reason for visit and visit diagnoses as follows: 9/18/2020 Reason for visit - Tracheostomy Change with a diagnosis of Acute Management of Tracheostomy. Included with this AVS are instructions for Tracheostomy Care, including suctioning and clearing a mucous plug. 9/23/2020 Reason for visit - Shortness of Breath with diagnosis of COPD. This documentation from R6's emergency room visit documents a letter from V35, hospital Registered Nurse (RN), that documents "(R6) was treated on 9/23/2020 for shortness of breath that required suctioning of (R6's) tracheostomy. (R6) requests that education and equipment should be available at all times in (R6's) room for self-treatment during emergent times. Thank you for your help." 10/1/2020 Reason for visit - Tracheostomy Change with a diagnoses of Encounter for Tracheostomy Tube Change. Included with this AVS are instructions for "mucous plug, trach tube" as well as instructions for tracheostomy care and cleaning. These instructions document "You have a tracheostomy tube that allows you to breathe. Mucus from your airway can collect inside the tube and block it. The buildup of thick music is called a mucous plug. It is important you take steps to prevent a mucous plug from blocking your trach tube. Suction your trach tube as told by your provider. Mucus can build up and thicken. If this happens your trach tube can become plugged. Cleaning prevents buildup of dried secretions that can block the tracheostomy tube. When cleaning your tracheostomy, it's important to be well prepared with the right supplies in case of an emergency including, for example, a manual ventilator bag."	S9999		

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S9999	Continued From page 10 R6's hospital records, dated 10/21/2020, document R6 presented to the emergency room with shortness of breath and "comes back for suctioning of (R6's) tracheostomy. (R6) has been here multiple times for that." These records document R6 had a small amount of dry secretions present with the left lower lung field revealing rales (abnormal lung sounds.) R6's "Clinical Impression" for this visit is documented as "Tracheostomy care." R6's Physician Orders, dated 10/26/2020, document staff are to perform trach care every shift and as needed. These orders document to suction R6's trach every 4 hours and as needed. On 10/20/2020 at 10:00am, R6 stated R6 has had to go to the hospital multiple times with "trach problems." R6 stated R6 will have trouble breathing due to the nurses not being able to do trach care as often as R6 needs it because they are too busy, as well as the staff do not go deep enough to get the mucous. R6 stated the staff check R6's oxygen saturation every once in awhile, but not too often. An open undated bottle of saline for humidity was noted at R6's bedside at this time. R6 stated R6 uses that with suctioning. R6 stated there is no emergency obturator or ambu bag in R6's room, and R6 has had emergencies where those should have been available. R6 stated R6 has pulled out his trach outer cannula because R6 could not breathe because the "tube was blocked" and R6 was "just trying to breathe. R6's suction tubing was located in a dingy ziplock bag that was not dated, as well as R6's suction tubing, humidifier bottle attached to the humidifier machine, trach collar and trach collar tubing were not labeled with date. R6 stated R6 is unsure when the facility changes the tubing,	S9999		

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S9999	Continued From page 11 trach collar, etc. On 10/20/2020 at 10:19am, V8, RN, stated the ambu bag should be in R6's room but V8 looked around and stated there was not one in R6's room. V8 had touched R6's used trach equipment and adjusted V8's protective eyewear multiple times without performing hand hygiene. V8 removed V8's gloves and proceeded to walk down the hall to the storage room to obtain some trach supplies and ambu bag without completing hand hygiene after removing V8's gloves. V8 stated V8 was unsure of when some of the trach tubing and humidifier bottles were placed in use for R6 and that the facility is not dating the items or documenting when the changes are happening. On 10/21/2020 at 9:00am, V8, Registered Nurse (RN), prepared R6's trach cleaning supplies. V8 provided trach care to R6's inner cannula, but did not clean the plate to R6's trach. V8 removed contaminated gloves, did not perform hand hygiene, opened the sterile water for trach care, donned sterile gloves, and began suctioning R6. V8 asked R6 if R6 had "another plug" and R6 shook R6's head. V8 continued to attempt to suction R6 with no success. R6 became anxious, took the suction catheter from V8, and attempted to suction R6's trach without success. R6 began forcefully coughing and was able to cough up thick mucous about the size of a dime. R6's oxygen saturation was unknown, and not being monitored prior to or during the procedure at this time. V8 was not wearing a gown while suctioning R6. R6 requested for V2, Director of Nursing (DON), to come assist with suctioning. At 9:25am, V2, DON, came in to R6's room. V2 was wearing a mask with straps around V2's neck and protective eyewear. V2 did not wear a gown	S9999		

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during the procedure. V8 went and got an oxygen saturation monitor and placed on R6's finger. R6's oxygen saturation was between 89% and 92%. V8 told V2, the mucous is "deep in there." At 9:29am, V2, DON's mask had fallen down under V2's nose, only covering V2's mouth. V2 attempted to suction R6 multiple times with no success. During this time, R6 was not encouraged or educated related to the use of R6's humidified trach mask. R6 was requesting additional suctioning. V2 stated to V8 that V2 wasn't sure that R6 should have more suctioning. R6 took R6's hand and used it to act out shooting R6's head. R6 began forcefully coughing again producing a large bloody mucous plug. This was followed by yellow mucous. The tubing to the suction machine had been laid on R6's bed. V2 picked up the tubing off the bed, attached a suction catheter to the open end of the contaminated suction tubing, and suctioned R6.

On 10/28/2020 at 7:20am, V22, Emergency Room Charge RN, stated R6 is constantly coming in the the emergency room several times with several "mucous plugs." V22 stated R6 has anxiety and has ended up removing R6's trach. V22 stated the facility R6 resides in is "neglectful" in trach care and "you can tell the facility does not complete trach care as often as R6 needs it." V22 stated the facility is neglecting to suction R6 properly as evidenced by multiple mucous plugs and emergency room visits. V22 stated not completing trach care as each resident needs can lead to mucus plugs and death.

2.) R1's Admission Record, dated 10/27/2020, documents R1's diagnoses including Anoxic Brain Damage, Tracheostomy status, Chronic Obstructive Pulmonary Disease (COPD), Asthma and Sleep Apnea.

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S9999	Continued From page 13 R1's Progress Notes, dated 7/9/2020 at 6:45am, documents R1 arrived to the facility from the hospital 7/8/2020 in the evening "post sepsis infection, bacterial infection in the lungs, and c-diff." R1 was to receive trach suctioning every 15-30 minutes, and the nurse was able to suction R1 every 30-45 minutes during the shift. R1 had rhonchi and crackles (abnormal lung sounds) throughout all lung fields both anterior and posterior. R1's Hospital Medical Records, dated 8/22/2020, document R1 has "tracheostomy in place and it is plugged up." These records document R1 presented with shortness of breath and in acute distress with decreased air movement. R1's "tracheostomy is plugged up. Suctioned and irrigated with saline obtained significant amount of thick mucus." R1 had significant improvement after R1's trach was suctioned. These notes document R1 had oxygen saturations from 51% to 80% at the facility prior to arriving at the emergency room. R1's diagnosis documented was Sepsis with Acute Hypoxic Respiratory Failure. R1 was discharged back to the facility on 8/25/2020. R1's Hospital Records from R1's hospital visit on 8/26/2020, document R1's Principal Final Diagnosis: Other foreign object in bronchus causing asphyxiation. These records document V36, Emergency Room Physician found R1's tracheostomy "plugged up" and that R1 was in acute distress. These records also document notes by V36 that R1's tracheostomy cannula was suctioned "removing significant amount of mucus plugging" with improvement following the removal of the mucus plugging with the "Clinical Impression" of R1's visit of "mucus plugging of	S9999		

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S9999	Continued From page 14 bronchi." These records document V22, Emergency Room Charge RN, spoke to V37, Licensed Practical Nurse, and V22 advised V37 to change R1's suctioning to every 30 minutes. R1's Progress Notes, dated 8/26/2020 at 5:20am, documents the unidentified nurse from the emergency room reported the hospital "removed three large mucous plugs" from R1's trach and the facility was notified by the emergency room R1 was to be suctioned every 30 minutes. Progress Notes, dated 8/26/2020 at 9:16am, are the last notes documenting trach suctioning every 30-45 minutes. R1's Treatment Administration Record (TAR), dated September and October 2020, documents R1 was to have R1's trach suctioned every four hours and as needed, as well as trach care every shift and as needed. There is no documentation in R1's TAR of suctioning R6's trach every 30 minutes. On 10/28/2020 at 7:20am, V22, Emergency Room Charge RN, stated R1 had been seen in the the emergency room several times with several "mucous plugs." V22 stated the facility R1 resides in is "neglectful" in trach care and "you can tell the facility does not complete trach care as often as R1 needs it." V22 stated the facility neglecting to suction R1 properly was evidenced by multiple mucous plugs and emergency room visits. V22 stated if the trach suctioning was completed as with proper technique and as it was supposed to be, R1 would not have been to the hospital with the trach plugging like R1 was. V22 stated not completing trach care as each resident needs can lead to mucus plugs and death.	S9999		

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S9999	Continued From page 15 (A) 3 of 3 300.610 a) 300.696 a) 300.696 c)2) 300.3240 a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.696 Infection Control a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed. c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department	S9999		

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S9999	Continued From page 16 of Health and Human Services (see Section 300.340): 2) Guideline for Hand Hygiene in Health-Care Settings Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidenced by: Failures identified required more than one deficient practice statement. A.) Based on observation, record review, and interview, the facility failed to ensure a staff member with an elevated temperature, multiple COVID (Novel Human Coronavirus Infection) symptoms, and exposure to a COVID positive person outside of the facility, did not report to and continued to work in the facility with COVID symptoms. The facility also failed to ensure staff were not medically screening themselves, and failed to implement infection control precautions to prevent the spread of COVID-19 in the facility. These failures have the potential to affect all 132 residents residing in the facility. These failures resulted in V14 working with multiple COVID symptoms, including a fever of over 100 degrees for 6 and a half hours, and using multiple tissues for upper head congestion, placing them in the open trash can at the front desk, screening staff entering the facility to provide care to the residents and environment inside the facility, which put the facility at risk for transmitting COVID throughout the facility. B. Based on observation, interview, and record	S9999		

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S9999	Continued From page 17 review, the facility failed to implement hand hygiene, and failed to disinfect the multiple resident use blood glucose test device (glucometer) after each use. These failures have the potential to affect 16 residents (R2, R14, R15, R16, R18, R20, R21, R22, R23, R26, R30, R45, R49, R50, R51, R52) reviewed during medication administration and use of the glucometers in the sample of 52. Findings include: a.) The facility's Infection Control - Interim policy addressing healthcare crisis related to Human Corona Virus, dated 10/6/2020, documents the Infection Preventionist or designee will monitor staff compliance with hand hygiene and Personal Protective Equipment (PPE) practices. Healthcare Providers (HCP) must not touch or adjust their facemask and if they do they must immediately perform hand hygiene. Staff will have screening for symptoms, possible exposures and temperature completed prior to starting their shift. "Staff may not perform self-screening." In Illinois, staff will be screened mid-shift or approximately every 4 hours. Any staff with a fever and/or onset of COVID-19 symptoms will result in the staff being screened and sent home with local health department being notified. Facility will utilize the following PPE and infection control precautions: Hand Hygiene is to be performed before and after all patient contact and before putting on and after removing PPE, including gloves. Universal Eye protection should be worn in addition to their facemask to ensure the eyes, nose and mouth are all protected from exposure to respiratory secretions during patient care encounters. After removing gloves, immediately perform hand hygiene. If there are gown shortages, gowns should be prioritized for aerosol-generating	S9999		

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S9999	Continued From page 18 procedures and care activities where splashes and sprays are anticipated. The facility's Interim COVID-19 Testing - Residents and Staff policy, dated 8/31/2020, documents staff with symptoms or signs of COVID-19 must be tested, and are expected to be restricted from the facility pending the results of COVID-19 testing. Staff who do not test positive for COVID-19 but have symptoms should follow facility policies on returning to work. On 10/19/2020 at 9:10am, V14, Receptionist, was sitting at the receptionist desk at the main entrance to the facility. V14 looked as though V14 did not feel well and when asked V14 stated, "I feel horrible" and had head congestion and stuffiness. V14 screened herself prior to V14's shift, and documented a temperature of 100.1 and "yes" for new symptoms as well as recent exposure or close contact with a COVID positive person outside of the facility. Mid-shift, V14 completed V14's screening per herself and V14's temperature was 100.9 and V14 answered "yes" to "Any new symptoms since the beginning of shift?" End of shift - Prior to leaving, V14 documented V14's temperature at 100.6 and yes to new symptoms. V14's timecard documents V14 checked in to work at 7:58am and left at 2:30pm, which was verified by V14's supervisor, V13, Human Resources. V14 is the receptionist that is responsible for screening the employees coming in to work at the facility and screened 26 staff (including self), potentially exposing the 25 other employees (V1, Administrator, V2, Director of Nursing (DON), V8, Registered Nurse (RN), V13, Human Resources (HR), V21, Care Plan Coordinator, V26 and V27 RN, V39, Housekeeping, V40, Dietary, V41, V42, V43, Housekeeping, V44, V54, Dietary, V45, V49, V50,	S9999		

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S9999	Continued From page 19 V53, Certified Nursing Assistant (CNA), V46, illegible title, V47, V51 Transport, V48, Marketing, V52 and V56, Therapy and V55, Vendor) prior to working with the residents throughout the facility, potentially exposing the residents throughout the day. V13 stated V13 was made aware about 12:30pm on 10/19/2020 and V2, DON, completed a rapid COVID screen on V14 that was negative. V14 remained working while symptomatic at the reception desk, despite V14's temperature and history of positive COVID exposure until 2:30pm. At 3:00pm, the trash can located at the desk of the reception area contained multiple tissues that were discarded while V14 was on duty. V1 provided the COVID positive test results for employees with testing performed between 10/19/2020 and 10/26/2020, documenting six employees (V2, V8, V14, V21, V26, V27) screened by V14, Receptionist, on 10/19/2020 tested positive for COVID. On 10/21/2020 at 9:25am, V2, Director of Nursing (DON), provided tracheostomy (trach) care and suctioning for R6. V2 was not wearing a gown during the procedure while standing within 2 feet of R6. R6 was forcibly coughing attempting to bring up the mucus from R6's tracheostomy. At 9:29am, V2's mask straps were behind V2's neck and V2's mask had moved below V2's nose. V2 made several attempts to suction R6's trach while V2's mask was not properly positioned over V2's nose, exposing R6 to V2 and V2 to R6. V8, Registered Nurse (RN) also suctioned R6 multiple times without a gown on as well as adjusted V8's protective eye wear with contaminated gloves after coming in contact with multiple items in R6's room including R6's tracheostomy supplies and contaminated suction catheter. V8 continued to care for the resident's in	S9999		

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the facility after providing cares and contaminating protective eyewear for V8.

On 10/19/2020, R6 had a COVID test performed, sent to the laboratory on 10/21/2020, and results reported on 10/23/2020 that R6 tested positive for COVID.

V1, Administrator, provided documentation eight residents (R6, R10, R29, R43, R44, R45, R46, R47) tested on 10/19/2020 tested positive for COVID.

On 10/26/2020 at 10:45am, V1, Administrator, stated V2, Director of Nursing, was out for the day. V1 stated V2 was "ill" and began running a fever over the weekend and was going to get a test for COVID on 10/26/2020. On 10/28/2020 at 9:15am, V1 stated V2 tested positive for COVID. V1 also stated V8, RN, had also tested positive for COVID.

Administrator stated the dietary staff have the potential to go between the two separate buildings at the facility to provide dietary services to the residents.

On 10/27/2020 at 9:20am, V38, Public Health Administrator, stated the facility reported V14, Receptionist, had reported to work "not feeling well." V38 stated the facility did not tell V38 that V14 was "feverish" and continued working until 2:30pm with symptoms of COVID. V38 stated V38 was "upset" to hear V14 continued working despite being symptomatic for COVID and exposing staff coming in to the facility. V38 stated with COVID being airborne/droplet, it is "maddening" and there was probable exposure, likely causing infections of others throughout the facility. V38 stated the facility policy should

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S9999	Continued From page 21 address the screening and attendance process and it should address employees not being allowed to self screen as well as work status if staff are symptomatic. The facility's Resident List Report documents 132 residents reside in the facility. b.) On 10/20/2020 at 11:11am, V4, Licensed Practical Nurse (LPN), obtained R14's blood glucose level. V4 opened the dry paper towel on the top of V4's medication cart and gathered supplies to perform the blood glucose finger stick. V4 used a lancet to puncture R14's finger and applied R14's blood to the testing strip in the glucometer. R14's blood glucose was 242. V4 placed the glucometer on top of the medication cart. V4 stated V4 is "allergic to bleach" so V4 "sanitizes (glucometer) with hand sanitizer." V4 took the bottle of hand sanitizer, applied a small amount to the paper towel, wiped the glucometer with the paper towel, obtained a dry paper towel and wiped the glucometer. V4 then wrapped the glucometer in the paper towel and sat the glucometer on the top of the medication cart. The hand sanitizer label documents the sanitizer contains 65% alcohol and that it is to be used for handwashing to decrease bacteria on the skin. The product labeling makes no efficacy claim for use as a surface disinfectant. On 10/20/2020 at 11:25am, V4, LPN, obtained a blood glucose level for R15 using a glucometer from the top of V4's medication cart that was wrapped in a paper towel. V4 used a lancet to pierce R15's finger and placed R15's blood on the testing strip that was inside the glucometer. V4 used the hand sanitizer on a paper towel to wipe the glucometer, and took a second paper towel	S9999		

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S9999	Continued From page 22 and wiped the glucometer again and wrapped the glucometer. On 10/20/2020 at 12:28pm, V19, LPN, performed a blood glucose level check on R18. V19 did not don gloves, and proceeded to use a lancet to pierce R18's skin to obtain a blood sample on the blood glucose test strip that had been placed inside the glucometer which was 333mg/dl. R18's Physician's Orders document medication orders including Novolog Insulin Flexpen 100 units/milliliters, inject 12 units subcutaneously before meals and to hold for a blood glucose level below 120. V19 administered the insulin to R18 without performing hand hygiene nor donning gloves. V19 returned to the medication cart and placed the glucometer with the contaminated test strip on the top of the cart, and then removed the blood glucose test strip that contained R18's blood with her bare hand and disposed of the strip. V19 did not disinfect the blood glucose glucometer after use on R18. On 10/20/2020 at 12:40pm, V19, LPN, used the same contaminated glucometer V19 used to obtain R18's blood glucose level to obtain R20's blood glucose level. V19 used a lancet to puncture R20's skin to obtain blood and placed the blood on the testing strip located inside the glucometer. V19 did not don gloves or perform hand hygiene prior to performing the blood glucose level check for R20. V19 brought the contaminated glucometer that still had the contaminated test strip inside the glucometer and placed it on the medication cart. V19 did not perform hand hygiene or don gloves prior to or after administering R20's Novolog insulin injection. On 10/20/2020 at 12:42pm, V19, LPN, used a	S9999		

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S9999	Continued From page 23 glucometer to perform a blood glucose level check for R21. R21 was standing at the medication cart when V19 used a lancet to pierce R21's skin to obtain a sample of R21's blood and placed the blood on the test strip located inside the glucometer. V19 then placed the contaminated glucometer on top of the medication cart without disinfecting the glucometer. V19 did not don gloves prior to performing the blood glucose test or perform hand hygiene. On 10/20/2020 at 12:53pm, R22 was sitting on the side of R22's bed. V20, LPN, entered R22's room, placed the bottle of blood glucose test strips on R22's bed. V20 performed a blood glucose test on R22 which read 173. V20 went to medication cart and placed the contaminated glucometer and bottle of test strips on top of the medication cart. V20 did not remove V20's contaminated gloves, and touched the medication cart, including opening drawers to obtain insulin medication to administer to R22. On 10/20/2020 at 12:59pm, V20, LPN, performed a blood glucose glucometer test for R23. V20 pierced R23's skin, placed R23's blood on the blood glucose testing strip and placed the contaminated machine on the medication cart. V20 did not perform hand hygiene after touching the contaminated monitor with V20's hands. On 10/20/2020 at 1:10pm, V20 entered R26's room to perform a blood glucose level test with a contaminated glucometer on R26. V20 placed the glucometer on R26's bed sheets on top of R26's bed that had brown debris on the sheets and R26 had shoes on in bed with debris on the bottom of R26's shoes.	S9999		

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S9999	Continued From page 24 On 11/9/2020, V1, Administrator, provided documentation of 15 residents (R2, R14, R15, R16, R18, R20, R21, R22, R23, R30, R45, R49, R50, R51, R52) who have the potential for blood glucose testing with the re-usable glucometer machines. The manufacturer's User's Manual for the facility's blood glucose meter dated 5/17/2016 documents, "Note: Important Safety Instructions." All parts of the kit are considered bio-hazardous. "The meter should be disinfected after use on each patient. This Blood Glucose Monitoring System may only be used for testing multiple patients when Standard Precautions and the manufacturer's disinfection procedures are followed." This manual documents to "not" use any product containing bleach to disinfect the meter and gives guidance on where to obtain a list of approved disinfectant wipes for use with the meter. This manual documents before testing, choose a clean, dry work surface and to use a "new pair of clean gloves before testing each patient." The facility's Glucometer Cleaning policy, dated 1/6/2020, documents the purpose of the policy is to prevent growth and spread of microorganisms and bloodborne pathogens. This policy documents the blood glucose monitor (glucometer) should be cleaned and disinfected between each resident test using a pre-moistened wipe or towel of 1ml (milliliter) or 5-6% sodium hypochlorite solution (household bleach) and 9ml water to achieve a 1:10 dilution final concentration of 0.5-0.6% sodium hypochlorite. "Wipe meter with 1:10 solution bleach wipe/towel until all surfaces of the glucometer are visibly wet." "Place glucometer on a clean surface such as a paper towel and allow	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002364	A. BUILDING: _____ B. WING _____	11/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 25 to air dry for no less than 3 minutes, or according to manufacturer instructions." The facility's Hand Hygiene/Handwashing policy, dated 1/10/2018, documents hand hygiene means cleaning your hands by using soap and water to wash hands or by using an antiseptic hand rub. This policy documents examples of when to perform hand hygiene including "before and after having direct contact with a patient's intact skin," after contact with blood, body fluids, excretions, non-intact skin, after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient and after glove removal. The facility's Injectable Medication Administration policy, dated 10/25/2014, documents to sanitize hands with approved sanitizer and put on gloves. This policy documents after administering the injection, remove and discard gloves and clean hands "by washing or using sanitizer." The facility's Medication Administration policy, dated 10/25/2014, documents the person administering medications adheres to good hand hygiene, which includes thoroughly washing hands prior to handling any medication, after coming in "direct contact" with a resident. Examination gloves are worn when necessary. Hand sanitization is done with an approved sanitizer between handwashing's, when returning to the medication cart or preparation area "(assuming hands have not touched a resident or potentially contaminated surface)." Hands are washed before putting on examination gloves and upon removal for administration of topical, ophthalmic, injectable, enteral, rectal, and vaginal medications."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 26 (A)	S9999		