STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015895	A. BUILDING: _____ B. WING _____	12/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR HEALTH CARE	485 SOUTH FRIENDSHIP DRIVE NASHVILLE, IL 62263

(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 Complaints 2049511/IL129232- F880L 2049570/IL129299-F880L 2049554/IL129287-F880L 2049560/IL129293-F880L A Focused Infection Control Survey/COVID-19 Focused Survey F 880 L	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.696a) 300.696c)2)7) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015895	A. BUILDING: _____ B. WING _____	12/22/2020

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S9999	Continued From page 1 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 of Health and Human Services (see Section 300.340): 2) Guideline for Hand Hygiene in Health-Care Settings 7) Guidelines for Infection Control in Health Care Personnel 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		

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	IL6015895	A. BUILDING: _____ B. WING _____	12/22/2020

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FRIENDSHIP MANOR HEALTH CARE	485 SOUTH FRIENDSHIP DRIVE NASHVILLE, IL 62263

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S9999	Continued From page 2 resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 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) These Regulations were not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to prevent/and or contain COVID-19 when the facility failed to 1. Ensure residents who tested positive for Covid-19 were isolated per current standards of practice to prevent the spread of Covid-19. 2. Ensure residents who had been exposed to Covid-19 had appropriate signage on the door, PPE available to staff, and bins to dispose of PPE in when exiting room 3. Ensure residents who were exhibiting symptoms of Covid-19 were assessed and	S9999		

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FRIENDSHIP MANOR HEALTH CARE	485 SOUTH FRIENDSHIP DRIVE NASHVILLE, IL 62263

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S9999	Continued From page 3	S9999		

placed in isolation precautions according to current standards of practice. 4. Ensure staff wore appropriate PPE (personal protective equipment) to prevent the spread of Covid-19. These systemic failures resulted in 72 residents (R1-R3, R5-R19, R21, R22, R24, R25, R28-R32, R33-R69, and R74-R81) testing positive for Covid-19, with death being the result for eight of these residents (R1, R8, R14, R15, R30, R31, R54, and R66) who were confirmed positive for Covid-19. These failures have the potential to affect all 83 residents residing in the facility.

Findings Include:

On 12/16/2020 at 9:16 AM, V1 (Administrator) stated the facility census on 12/09/2020 was 83.

The facility resident Covid-19 testing logs document one staff member tested positive Covid-19 on 9/15/2020 and all residents were tested for Covid-19 with negative test results on 9/15/2020, 9/22/20, 11/06/20, and 11/10/2020.

The facility resident test log documents on 11/24/2020 that R33 tested positive for Covid-19.

The facility resident test log documents on 12/01/2020 34 residents tested positive for Covid-19 (R1, R2, R3, R7, R11, R12, R13, R14, R15, R16, R24, R28, R29, R30, R31, and R35-R53). The log documents on "12/02/2020 all positive residents were moved to the Covid-19 unit. The residents on the Alzheimer's unit who tested positive were placed in rooms behind a zippered wall but remained on the memory care unit due to wandering and their safety." The log documents staff, residents, families, IDPH, and local health department were all notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015895	A. BUILDING: _____ B. WING _____	12/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR HEALTH CARE	485 SOUTH FRIENDSHIP DRIVE NASHVILLE, IL 62263

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S9999	Continued From page 4	S9999		

The facility resident test log documents on 12/07/2020 "residents on memory care tearing the zipper wall down. Danger of being tangled in it, falling. Spoke with V3 (local health department administrator). Okay with treating all of memory care as Covid-19 positive. Due to the risk of moving residents off and not being secured with locked doors."

The facility resident test log documents on 12/10/2020, 25 residents tested positive for Covid-19 (R5, R6, R8, R9, R10, R17, R21, R22, R25, R54-69), R10, R22, and R54 reside on the memory care unit.

On 12/16/2020 at 1:30 PM, V1 (Administrator) confirmed R33 was the first resident in house that tested positive. V1 stated the residents were not tested in October of 2020 because the facility did not have any staff test positive for Covid-19. V1 stated after she (V1) tested positive on 11/04/2020 they began testing the residents weekly and have not stopped. V1 stated R33 had been treated at the emergency room and when she returned to the facility was placed on the "yellow" unit for 14 days. During that time frame R33 tested positive for Covid-19. V1 stated R33 was then moved to the dedicated Covid-19 unit and was the only resident over there until 12/02/2020 when residents began testing positive.

R1's clinical record documents a positive Covid-19 test date of 12/02/2020. R1's clinical record does not indicate R1 was being treated for end of life services prior to R1's positive Covid-19 diagnosis. R1's medical record documents R1 expired at the facility on 12/09/2020. R1's Certificate of Death Worksheet confirms the date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015895	A. BUILDING: _____ B. WING _____	12/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR HEALTH CARE	485 SOUTH FRIENDSHIP DRIVE NASHVILLE, IL 62263

(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
S9999	Continued From page 5	S9999		

of death of 12/09/2020 and lists the cause of death as congestive heart failure and diabetes. On 12/16/20 at 3:12 PM, V25 (Physician) stated he would consider Covid-19 to be a contributing factor in R1's death even though it is not listed on R1's death certificate.

R8's medical record documents a positive Covid-19 test date of 12/10/2020. R8's medical record does not indicate R8 was being treated for end of life services prior to R8's positive Covid-19 diagnoses. R8's medical record documents R8 expired at the facility on 12/12/2020. R8's Certificate of Death Worksheet confirms the date of death of 12/12/2020 and lists cause of death as pneumonia and Covid-19.

R14's medical record documents a positive Covid-19 test date of 12/02/2020. R14's medical record does not indicate R14 was being treated for end of life services prior to R14's positive Covid-19 diagnosis. R14's medical record documents R14 expired at the facility on 12/09/2020. R14's Certificate of Death Worksheet confirms the date of death of 12/09/2020 and lists cause of death as pneumonia and Covid-19.

R15's medical record documents a positive Covid-19 test date of 12/02/2020. R15's medical record documents R15 was receiving hospice services that were discontinued on 10/5/2020 related to resident being stable. R15's medical record does not document end of life services between 10/5/2020 and 12/02/2020 when R15 tested positive for Covid-19. R15's medical record documents R15 expired at the facility on 12/09/2020. R15's Certificate of Death Worksheet confirms the date of death of 12/09/2020 and lists the cause of death as pneumonia and Covid-19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015895	A. BUILDING: _____ B. WING _____	12/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR HEALTH CARE	485 SOUTH FRIENDSHIP DRIVE NASHVILLE, IL 62263

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S9999	Continued From page 6	S9999		

R30's medical record documents a positive Covid-19 test date of 12/02/2020. R30's medical record does not document R30 was receiving end of life services prior to R30's positive Covid-19 diagnosis. R30's medical record documents R30 expired at the facility on 12/11/2020. R30's Certificate of Death Worksheet confirms the date of death as 12/11/2020 and lists cause of death as pneumonia and Covid-19.

R31's medical record documents a positive Covid-19 test date of 12/01/2020. R31's medical record does not indicate R31 was receiving end of life services prior to R31's positive Covid-19 diagnosis. R31's medical record documents R31 expired at the facility on 12/12/2020. R31's Certificate of Death Worksheet confirms the date of death as 12/12/2020 and lists the cause of death as pneumonia and Covid-19.

R54's medical record documents a positive Covid-19 test date of 12/10/2020. R54's medical record does not indicate R54 was receiving end of life services prior to R54's positive Covid-19 diagnosis. R54's medical record documents R54 expired at the facility on 12/15/2020. R54's Certificate of Death Worksheet confirms the date of death as 12/15/2020 and lists the cause of death as pneumonia, Covid-19.

R66's medical record documents a positive Covid-19 test date of 12/10/2020. R66's medical record does not indicate R66 was receiving end of life services prior to R66's positive Covid-19 diagnosis. R66's medical record documents R66 expired at the facility on 12/17/2020. R66's Certificate of Death Worksheet confirms the date of death as 12/17/2020 and lists the cause of death as pneumonia, Covid-19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015895	A. BUILDING: _____ B. WING _____	12/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR HEALTH CARE	485 SOUTH FRIENDSHIP DRIVE NASHVILLE, IL 62263

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S9999	Continued From page 7	S9999		

1.On 12/09/2020 at 6:15 AM, V2 (Director of Nurses) stated the facility started out with one Covid-19 unit and then had some residents test positive for Covid-19 on the Alzheimer's unit (R2 and R3 tested positive on 12/20/2020). V2 stated they attempted to put a plastic zip barrier up but the residents on the Alzheimer's unit were pulling it down, so they are considering all the Alzheimer's unit a Covid-19 unit.

On 12/09/2020 at 11:51 AM, V1 (Administrator) stated the facility test results from 12/01/2020 came back on 12/02/2020 with two positive residents (R2 and R3) on the Alzheimer's unit. V1 stated they moved R2 and R3 to an area of the unit by themselves and put up a zipper wall barrier. V1 stated they could not keep R2 and R3 behind the zipper wall and so they rapid tested everyone on the unit and had four more residents test positive (R11, R12, R13, and R28). V1 stated she spoke with V3 (local health department administrator) and they took the zipper wall down because the residents were pulling it down and getting tangled in it. When asked why they didn't move the residents who tested positive to the Covid-19 unit V1 stated it is not secure. There are three doors that go outside that are not locked so we were afraid they would elope if we transferred them to that unit.

On 12/09/2020 at 1:03 PM, V3 (local health department administrator) stated V1 (Administrator) spoke with her related to concerns about moving residents diagnosed with Alzheimer's who tested positive for Covid-19 to the Covid-19 unit. V3 stated the facility tried the barrier on the Alzheimer's unit and the residents were tearing it down. V3 stated they don't have the staff to do 1:1 with the residents who are positive. V3 stated the facility is trying to keep the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015895	A. BUILDING: _____ B. WING _____	12/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR HEALTH CARE	485 SOUTH FRIENDSHIP DRIVE NASHVILLE, IL 62263

(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
S9999	Continued From page 8	S9999		

residents who are positive isolated in their rooms. V3 stated the facility did inform her and they are doing the next best thing since they don't have staff to do 1:1 with the residents.

The facility resident roster not labeled dated 12/9/2020 documents R2, R3, R10, R11, R12, R13, R22, R23, R28, R54, R66, R68, and R70-R75 reside on the Alzheimer's unit.

The facility resident testing log documents positive Covid-19 test results for R2 and R3 on 12/02/2020, R11-13 on 12/04/2020, R66 on 12/09/2020, and R10, R22, R23, R28, R54, R68, R73 on 12/10/2020, and R74 and R75 on 12/14/2020. This indicates 15 residents out of 18 residents residing on the Alzheimer's unit tested positive for Covid-19 between 12/02/2020 and 12/14/2020.

On 12/09/2020 at 8:45 AM, R11 was observed lying in her bed in her room. V2 (Director of Nurses) entered R11's room and covered R11 with a sheet. V2 exited R11's room, removed her gloves and washed her hands. V2 did not change her gown or her N95 and did not change and/or clean her eye protection. There was no signage on the door indicating R11 was on isolation precautions and/or no disposal bins to dispose of used PPE. The facility testing log indicates R11 tested positive for Covid-19 on 12/04/2020.

On 12/09/2020 at 8:45 AM, R2 was observed ambulating in the hallway and standing next to the nurse's station. R2 was not redirected or asked to wear a mask by V2 (DON), V12 (Licensed Practical Nurse/LPN) or V13 (Certified Nursing Assistant/CNA). R22 was observed ambulating in the hallways and standing within three feet of R2 at times with no redirection by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015895	A. BUILDING: _____ B. WING _____	12/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR HEALTH CARE	485 SOUTH FRIENDSHIP DRIVE NASHVILLE, IL 62263

(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
S9999	Continued From page 9	S9999		

V2, V12, or V13. At 9:00 AM V12 (LPN) stated R2 was one of the first residents who tested positive for Covid-19 on the unit she resides on. The facility testing logs documents R2 tested positive for Covid-19 on 12/02/2020 and R22 tested positive for Covid-19 on 12/10/2020.

On 12/10/2020 at 12:45 PM, R2 and R10 were observed sitting in a group room less than three feet apart. V13 (CNA) confirmed R2 had tested positive for Covid-19 and R10 had tested negative for Covid-19 on the last facility test date (12/01/2020). The residents were not redirected/encouraged to return to their room, sit more than six feet apart, or wear a mask.

On 12/10/2020 at 12:55 PM, when asked about positive residents being near negative residents V16 (LPN) stated we can't stop them, and we can't move them to the Covid-19 unit, and we can't keep them contained.

On 12/10/2020 between 12:58 PM and 1:15 PM, R2 (COVID Positive) was observed walking down the hallway using the handrails to steady herself, walking into the room on the hall labeled Female restroom, ambulating between the common area and the nurse's station and sitting within three feet of R10 (R10 tested positive for Covid-19 on 12/10/2020 after this observation) in the common area. At 1:10 PM, R2 is given a drink by V16 (LPN) with no prompting or redirection observed.

On 12/10/2020 at 1:15 PM when asked what had been implemented to prevent the spread of Covid-19 on the unit V13 (CNA) stated they had tried a zipper wall until they determined the whole unit probably had Covid-19 so they moved the wall to the outside of the unit. V13 stated they did have a staff member one to one with R2 for a few

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015895	A. BUILDING: _____ B. WING _____	12/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR HEALTH CARE	485 SOUTH FRIENDSHIP DRIVE NASHVILLE, IL 62263

(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
S9999	Continued From page 10	S9999		

days, but the staff member was scared of Covid-19 so he didn't think that helped. V13 stated he sits with R2 in his free time and constantly attempts to redirect her. V13 stated he had also moved the couch out of the common area and would spread the chairs six feet apart when he got to work but the residents would move the chairs closer. V13 stated R2 and R10 wander and R2 will fall asleep at times in chairs in other resident rooms. When asked about signs on the doors of resident rooms who had tested positive V13 confirmed there is no signage on the door of the rooms for the residents who are on isolation precautions after testing positive for Covid-19. V13 stated staff wear the same PPE (personal protective equipment) when providing care to residents who have tested negative for Covid-19 and residents who have tested positive for Covid-19.

On 12/10/2020 at 1:25 PM, V16 (LPN) stated they made the Alzheimer's unit a Covid-19 unit because they knew the residents who reside on this unit were going to get it.

On 12/10/2020 at 1:25 PM, R10 was heard coughing. When asked if that was a new cough for R10, V16 (LPN) stated yes, V16 (LPN) then made a phone call and stated R10 was to be rapid tested. The facility Covid-19 test log documents R10 tested positive for Covid-19 on 12/10/2020.

R10's daily vital sign sheet documents R10's temperature on 12/7/2020 on 6 am-2 pm shift was 99.1 and on 10 pm - 6 am shift was 99.2.

On 12/16/2020 at 9:16 AM, V2 (Director of Nurses) stated R10 had a low grade temp on 12/7/2020 but they didn't do anything different

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015895	A. BUILDING: _____ B. WING _____	12/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR HEALTH CARE	485 SOUTH FRIENDSHIP DRIVE NASHVILLE, IL 62263

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S9999	Continued From page 11	S9999		

because they were treating the whole hall like it was Covid-19 positive.

On 12/16/2020 at 9:16 AM when asked about using the same PPE to care for Covid-19 positive and Covid-19 negative residents on the Alzheimer's unit V1 (Administrator) stated we put the zipper wall up outside the unit. That is where the staff change their PPE. V1 (Administrator) stated unfortunately the residents who were Covid-19 positive on that unit were ambulatory, and we don't have the staff to do 1:1 with the residents who have tested positive for Covid-19.

On 12/16/2020 at 9:16 AM, when asked about interventions to prevent the spread of Covid-19 on the unit, V2 (Director of Nurses) stated we would put masks on the residents, and they would rip them off. When asked why staff were not observed redirecting Covid-19 positive residents V2 stated this surveyor was only on the unit for approximately thirty minutes, "maybe the staff redirected them before you got there." Reminded V2 this surveyor was on the unit on two separate days and no observations were made of staff redirecting Covid-19 positive residents to stay in their room or not be within 6 feet of residents who had tested positive for Covid-19. When asked about signage on the doors of residents who were on isolation precautions V2 stated all the staff are well aware of which residents were positive for Covid-19 and which residents were negative.

2. The facility face sheet documents R5 was admitted to the facility on 3/16/2016 with diagnoses that include atrial fibrillation, hypertension, asthma, and heart failure.

R5's MDS (Minimum Data Set) dated 9/17/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015895	A. BUILDING: _____ B. WING _____	12/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR HEALTH CARE	485 SOUTH FRIENDSHIP DRIVE NASHVILLE, IL 62263

(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
S9999	Continued From page 12 documents R5 is independent with cognitive skills for daily decision making. On 12/09/2020 at 6:30 AM, R5 was observed standing at the door of his room with no mask requesting ice. R5 stated to this surveyor his wife (R30) tested positive and since he was with her, he has to be quarantined. R5 stated he just stays in his room. There was no signage observed on R5's door or near his room noting that R5 was on isolation precautions. There were no disposal bins for PPE (personal protective equipment) and no PPE noted outside or on the door of R5's room. On 12/10/2020 at 12:00 PM observed R5's room and the room (R25's) across the hall from R5's room to have signs on the doors that said, "Do Not Enter." These signs were not on the doors during observation on 12/09/2020. The facility test log documents R25 tested positive for Covid-19 on 12/10/2020. On 12/09/2020 at 11:51 AM, V1 (Administrator) stated on 12/01/2020 R5 visited with his wife R30 in a common area. V1 stated on 12/02/2020 they received the facility Covid-19 test results and R30 tested positive for Covid-19. V1 stated R5 also had a window visit with his daughter and had passed her his cell phone through the window. V1 stated R5 refused to move to the "yellow zone" (an area designated for residents with potential exposure to Covid-19). V1 stated we instructed R5 to stay in his room and he did. V1 stated R5 tested positive for Covid-19 on 12/09/2020 and was moved to the Covid-19 unit. On 12/15/2020 at 9:16 AM, V2 (Director of Nurses) stated she was not aware of the situation with R5 and R30. V2 stated she spoke with V1	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015895	A. BUILDING: _____ B. WING _____	12/22/2020

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S9999	Continued From page 13	S9999		

(Administrator) and was told R5 refused to go to the yellow zone for 14 days after he was exposed to Covid-19. V2 stated staff do not go in his room. R5 is very independent and does not want staff in his room. V2 stated they had put signs on R5's door but R5 must have taken them down. When asked about PPE V2 stated if staff had to go in his room, they would step into the solarium which is next to his room and change gowns leaving their clean gown in the solarium. When asked where they would dispose of the dirty PPE when exiting R5's room V1 (Administrator) who was in the interview stated staff would take it to the soiled utility room to dispose of it. V1 stated the soiled utility room is located a few doors down from R5's room.

3. R9's facility admission record sheet dated 12/11/2020 documents R9 was admitted to the facility on 2/13/15 with diagnoses that include dementia, diabetes, and hypertension.

R9's MDS (Minimum Data Set) dated 10/06/2020 documents R9 is independent with cognitive skills for daily decision making.
On 12/10/2020 at 12:25 PM, while doing observation of V15 cleaning R9's room, R9 was observed sitting in her room in a chair and was coughing. When asked if the cough was new for R9, V9 (unit aid) stated yes and she had told V12 (LPN) that morning. V9 (unit aid) was unable to recall the time she had reported R9's cough to V12 (LPN).

On 12/10/2020 at 12:26 PM V12 (LPN) stated she hadn't heard R9 coughing until just now. V12 stated she wasn't coughing when she gave R9 her medication that morning. V12 stated V9 had not reported to her R9 was coughing. V12 stated they were going to do a rapid test to see if R9

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S9999	Continued From page 14	S9999		

tested positive for Covid-19. There was no signage on R9's door and no PPE or disposal bins in or near R9's room indicating R9 was placed on isolation precautions after she developed the symptom of coughing.

On 12/6/2020 at 9:16 AM when asked what her expectations would be when R9 developed a cough and V9 (unit aid) reported it to V12 (LPN), V2 stated she would expect the nurse to assess R9 when she was told of R9 developing the new symptoms of coughing. The facility Covid-19 test log documents R9 tested positive for Covid-19 on 12/10/2020.

4. On 12/10/2020 at 1:50 PM, V17 (CNA) was observed in the hallway on the Covid-19 unit. V17 was wearing a gown, N95, and eyeglasses. V17 stated she tested positive for Covid-19 last Monday and only works on the Covid-19 unit. When asked if she wears eye protection, V17(CNA) stated since she has already tested positive for Covid-19 she doesn't think she needs to.

On 12/10/2020 at 1:55 PM, V18 (CNA) was observed with a N95 mask and gown on standing behind the nurse's station on the Covid-19 unit. V18 pulled down her N95 and ate a cookie and took drinks from a cup. V18 was not observed to be wearing eye protection. When asked about eye protection V18 stated she wears eyeglasses and she was not aware she was supposed to be wearing eye protection. V18 stated she is new and will be working on both Covid-19 units and the non-Covid-19 units.

On 12/10/2020 at 1:55 PM, V19 (LPN) was observed behind the nurse's station on the Covid-19 unit wearing glasses, N95 mask, and a

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FRIENDSHIP MANOR HEALTH CARE	485 SOUTH FRIENDSHIP DRIVE NASHVILLE, IL 62263

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S9999	Continued From page 15	S9999		

gown. When asked about eye protection V19 stated she had eye protection on. V19 stated she wears goggles when she is in a room providing care to the residents.

On 12/09/2020 at 6:15 AM, V2 (Director of Nurses) stated staff wear gowns, eye protection, and N95 throughout their shift and they have a clean N95 that is used when they are working off the covid-19 unit and a dirty N95 that is used when they are working on the covid-19 unit.

On 12/10/2020 at 4:15 PM, V1 (Administrator) stated staff are supposed to wear eye protection however two of the staff observed not wearing eye protection on the Covid-19 unit have tested positive for Covid-19 and eye protection is for the staff not the residents. V1 stated V18 (CNA) who was observed not wearing eye protection on the Covid-19 unit was just intimidated by talking to this surveyor and had been given eye protection to wear prior to beginning work at the facility.

On 12/11/2020 at 1:18 PM, V4 (Medical Director) stated he was aware the facility was experiencing an outbreak of Covid-19. When asked if he would agree the facility should follow current CDC guidelines in relation to cleaning, cohorting residents, isolation precautions, and PPE, V4 (Medical Director) stated he would certainly agree and expect CDC guidelines to be followed. V4 stated some of the residents on the Alzheimer's unit can become hostile with redirection but it would certainly be worth making the best effort possible. When asked if eyeglasses were appropriate eye protection V4 stated he had not seen that and wearing eye protection is not a bad idea. When asked what he would expect the facility to do if someone became symptomatic V4 stated he would expect them to be quarantined

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S9999	Continued From page 16 as soon as possible and then be tested. The facility policy "Emergency Procedure-Pandemic Coronavirus dated March 2020 documents under Infection Prevention and Control, "Cleaning and disinfection for pandemic coronavirus follows the general principles used daily in health care settings (1:10 solution of bleach in water or any other EPA approved product). Infection Prevention and control policies require staff to use Standard and/or Droplet Precautions (i.e., mask for close contact with symptomatic residents). The IPCC (Infection Prevention Control Committee) shall develop procedures to cohort symptomatic residents or groups using one or more of the following strategies: confining symptomatic resident and their exposed roommates to their room. Placing symptomatic residents together in one area of the facility. Under increased transmission based precautions .... the policy documents under Isolation Halls Defined, "Facility will designate separate quarantine areas as follows: Covid positive unit: those residents that have tested positive for Covid-19 will cohort in the South Dining Room ...Covid-19 negative but exhibiting symptoms unit: those resident that have yet to have a positive test result but display symptoms consistent with Covid-19. The individuals in this area will be quarantined individually unless there is a crisis in room shortage for this area ..." (A)	S9999		