STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009989	A. BUILDING: _____ B. WING _____	12/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON LIVING AND REHABILITATION CENT	811 SOUTH 10TH STREET OREGON, IL 61061

(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 A Focused Infection Control Survey/COVID-19 Focused Survey was conducted by the Illinois Department of Public Heatlh on December 2, 2020. . Survey Census: 62 Total Sample: 11	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.696 a)c)7) 300.1020 a)b) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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): 7) Guidelines for Infection Control in Health Care Personnel Section 300.1020 Communicable Disease Policies a) The facility shall comply with the Control of Communicable Diseases Code (77 Ill. Adm. Code 690). b) A resident who is suspected of or diagnosed as having any communicable, contagious or infectious disease, as defined in the Control of Communicable Diseases Code, shall be placed in isolation, if required, in accordance with the Control of Communicable Diseases Code. If the facility believes that it cannot provide the necessary infection control measures, it must initiate an involuntary transfer and discharge pursuant to Article III, Part 4 of the Act and Section 300.620 of this Part. In determining whether a transfer or discharge is necessary, the burden of proof rests on the facility. These requirements are not met as evidenced by:	S9999		

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Based on observation, interview and record review the facility failed to implement infection control policies and recommendations from the Centers of Disease Control (CDC) regarding isolation of COVID-19 residents related to cohorting of COVID-19 residents, ensuring signage for the specific use of PPE (personal protective equipment) was posted, and ensuring staff wore the appropriate PPE to prevent the spread of COVID-19. These failures have the potential to infect high risk residents with COVID-19 and spread the disease of COVID-19 to negative residents. This applies to 11 of 11 residents (R1-R11) reviewed for infection control in the sample of 11.

The findings include:

The facility's Resident Roster dated November 30, 2020 showed there were 62 residents residing in the facility. The Roster showed that 18 residents are COVID-19 positive and 9 residents are listed as Patients Under Investigation (PUI's), for COVID-19 due to exhibiting COVID-19 symptoms or being exposed to a resident that is COVID-19 positive.

An email dated December 1, 2020 to the Illinois Department of Public Health showed that as of November 30, 2020, 24 residents and 11 staff members had tested positive for COVID-19. The email also showed one resident with COVID-19 had expired.

1. The Resident Roster dated November 30, 2020 showed R2, R4, and R5 were listed as PUI's.

On November 30, 2020 at 9:15 AM, an initial tour of the facility's locked memory care unit was

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completed with V3 Certified Nursing Assistant (CNA). R4 was seated in her room with her door open. An isolation/PPE cart was placed in hallway by R4's door. No isolation signage was noted on R4's door. When V3 CNA was asked about the isolation cart outside of R4's door, V3 stated, "She (R4) is supposed to have a droplet isolation sign on her door. She is on isolation because her roommate tested positive for COVID-19 last night and was moved to the COVID unit. If you go in her room, you need to wear a gown, surgical mask over your N-95 mask, gloves and a face shield."

On November 30, 2020 at 9:18 AM, R2 was seated in her room with her door open. No isolation signage was noted on R2's door. V3 CNA stated, "(R2) is supposed to be on droplet isolation too. Her roommate tested positive for COVID-19 this weekend."

On November 30, 2020 at 9:25 AM, this surveyor and V3 CNA observed V5 (Hospital Phlebotomist) enter R2's room with only an N95 mask and goggles on. V3 CNA made no attempt to inform V5 that R2 was a patient under investigation for COVID-19 and on droplet isolation. At 9:35 AM, V5 exited R2's room. When V5 was asked why she did not don the PPE required for droplet isolation, V5 stated, "I was just here to draw (R2's) blood. I was not aware she is on droplet isolation. There is no isolation sign on her door."

On November 30, 2020 at 9:28 AM, R5 was seated in her room with her door open. No isolation signage was noted on R5's door. V3 CNA stated R5 should be on droplet isolation because R5's roommate had recently tested positive for COVID-19.

On November 30, 2020 at 9:30 AM, V4 Registered Nurse stated, "We are not even supposed to have PUI's on this unit (memory care unit). (R2, R4, and R5) are supposed to

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have droplet isolation signs on their doors. Before you enter their rooms, staff must wear an N-95 mask covered by a surgical mask, a gown, a face shield, and gloves."
On November 30, 2020 at 10:20 AM, V2 Director of Nursing (DON)/Infection Preventionist stated, "We currently have PUI overflow residents on our memory care unit. All PUI residents are on droplet isolation and should have an isolation sign on their door. Prior to entering a PUI room, staff must don a surgical mask over their N95 mask, gown, face shield and gloves. We assume all PUI residents are COVID-19 positive due to being exposed or having symptoms."

2. The Resident Roster dated November 30, 2020 showed R1, R10, and R11 were listed as COVID-19 positive. The Roster also showed R6-R9 were listed as PUI's.
R6's COVID-19 test dated November 28, 2020 showed R6 was negative for COVID-19.
R7's COVID-19 test dated November 29, 2020 showed R7 was negative for COVID-19.
R8's COVID-19 test dated November 28, 2020 showed R8 was negative for COVID-19.
R9's COVID-19 test dated November 29, 2020 showed R9's results as "inconclusive" for COVID-19.

On November 30, 2020 at 9:50 AM, a tour of the facility's PUI rooms was completed with V2 Director of Nursing (DON)/Infection Preventionist. No isolation signage was noted on the entry doors of the PUI unit. No isolation signage was noted on the doors of the PUI rooms. On November 30, 2020 at 9:52 AM, on the PUI unit, R6 and R7 (both PUI residents/COVID-19 negative) were seated in their room with the door to their room open. R6 and R7 were not wearing masks. Directly across the hall from R6 and R7's

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room, R11 (COVID-19 positive) was seated in their room with the door to his room open. R11 was not wearing a mask.
On November 30, 2020 at 9:54 AM, on the PUI unit, R8 (PUI resident/COVID-19 negative) and R9 (PUI resident/COVID-19 "inconclusive" result) were seated in their room with the door to their room open. R8 and R9 were not wearing masks. Directly across the hall from R8 and R9's room, R10 and R11 (both COVID-19 positive) were seated in their room with the door to their room open. R10 and R11 were not wearing masks.
On November 30, 2020 at 9:55 AM, V2 DON stated, "Yes, we do have COVID positive residents on the PUI unit. We just haven't had time to move them to the COVID unit yet."
On November 30, 2020 at 3:15 PM, V2 DON stated, "The COVID-19 negative residents in the PUI unit should have been separated immediately from the COVID-19 positive residents on the PUI unit. (V1 Administrator) had asked one of our nurses to move the plastic barrier wall that separates the COVID-19 unit and PUI unit to incorporate two (COVID-19 positive rooms) this weekend. It was overlooked and never got done. The doors of the rooms of COVID-19 positive residents should be closed. If they can't be closed due to safety reasons, the residents should have a mask on."

On November 30, 2020 at 12:28 PM, V12 Medical Director stated, "The facility is currently in the middle of a COVID-19 outbreak. I know they had multiple positive cases turn up over the weekend ...If a resident becomes symptomatic, tests positive for COVID-19, or is a PUI, they should immediately be placed on droplet isolation with a sign on the door of their room. Doors of COVID-19 positive residents should be shut. If they can't have the door shut, the residents need

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S9999	Continued From page 6 to wear masks. COVID-19 positive residents should be in a separate area from PUI residents, not across the hallway." On December 1, 2020 at 11:35 AM, V14 County Public Health Administrator stated, "Any resident that receives an "inconclusive" result on their COVID-19 test should be treated like they are positive. They should not be cohorted with a resident that is COVID-19 negative or positive. That resident should be isolated in his/her own room. They should be retested immediately." On December 1, 2020 at 11:43 AM, V1 Administrator stated R8 and R9 should not have been cohorted or in the same room since R9's COVID-19 test result dated November 29, 2020 was "inconclusive". V1 stated, "Since (R9's) result was inconclusive, we would be unsure if she has COVID-19." The facility's COVID-19 Outbreak Control Policy dated September 23, 2020 showed, "A resident with known or suspected COVID-19, immediate infection prevention and control measures will be put in place .....c. In any event a resident with suspected or unconfirmed COVID-19 should not be cohorted with residents who are known to be positive for active COVID-19 disease until such a time as they are confirmed to be positive through Sars-CoV2 testing ...f. Place resident on both contact and droplet precautions ..." (B)	S9999		