STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000228	A. BUILDING: _____ B. WING _____	03/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF ARLINGTON HEIGHTS	715 WEST CENTRAL ROAD ARLINGTON HTS, IL 60005

(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	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.696a) 300.696b) 300.696c) 300.1210b) 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. b) A group, i.e., an infection control committee, quality assurance committee, or other facility entity, shall periodically review the results of investigations and activities to control infections. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 resident to meet the total nursing and personal care needs of the resident. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to implement infection control policies and recommendations from the Centers for Disease Control (CDC) regarding isolation of COVID-19 residents in regards to cohorting of COVID-19 residents and designating staff for positive COVID-19 residents. The facility failed to keep newly admitted residents under isolation precautions for 14 days per CDC recommendations and failed to keep the doors of the COVID-19 positive residents closed to prevent the spread of COVID-19. The facility also failed to have appropriate signage on resident doors in regards to isolation precautions. 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 all 87 residents residing in the facility. The findings include: The undated list provided by the facility on March 1, 2021 shows that there are 4 residents "who have confirmed cases of COVID-19" (R1, R2, R3,	S9999		

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S9999	Continued From page 2 & R4). 1. On March 1, 2021, at 9:30 AM, V2, Director of Nursing,stated, they had 4 residents that were confirmed COVID-19 positive. They were "isolating them in place". V2 stated the facility did not have a designated COVID-19 uni,t so the residents that were confirmed COVID-19 positive were residing in their original rooms. There are staff for each "unit" of the facility . The staff are working with both the negative and positive COVID-19 residents. The facility did not have enough residents' "positive" to make another COVID-19 unit. V2 stated, they had a unit in November but have since closed the unit. If residents are "alert enough" they can have their doors closed, otherwise the doors are left open if they are fall risks. On March 1, 2021, at 1:31 PM, R2's door was closed to his room. There was no signage on his door stating the type of isolation in place. There was an isolation cart outside of the door. R3's door to room was open. The room was right next to the nurse's station. No isolation signage was observed on the door. An isolation cart was noted outside of the room. Both positive COVID-19 residents were on a hallway with other residents that had isolation carts outside of their rooms . Some of the rooms had no isolations carts. No one had a sign on their door to indicate what type of isolation was in place. Some resident's doors were open and some were closed. On March 1, 2021, at 2:10 PM, V11, Registered Nurse, stated R2 and R3 were both positive for COVID-19. She was taking care of them and the non- positive residents located on the hall.	S9999		

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On March 1, 2021, at 1:45 PM, R1's door was closed . No signage indicating type of isolation was noted. There was an isolation cart outside of door. R4's door was initially closed and then staff left it open once they came out of room. No isolation sign was located on the door. Isolation cart noted outside of door.Covid-19 positive residents were noted on a hallway with non-positive residents No one had a sign on their door to indicate what type of isolation they were on. Some resident's doors were open and some were closed. V14 Registered Nurse (RN) stated the rooms should have a sign saying residents are on isolation. She stated that R4's door was left open because he is a fall risk and she wants to be able to see him. She also verified that R1 and R4 were positive for COVID-19 and they both were her residents. She is also taking care of the other residents that are negative.

R1's PCR COVID-19 laboratory test result collected on February 15, 2021 and reported on February 17, 2021 shows, "SARS CoV 2 RNA-Detected. A detected result is considered a positive test result for COVID-19. This indicates that RNA from SARS-CoV-2 (formerly 2019-nCoV) was detected, and the patient is infected with the virus and presumed to be contagious."

R2's PCR COVID-19 laboratory test result collected on February 23, 2021 and resulted on February 24, 2021 shows, "SARS CoV 2 (COVID-19) Positive".

R3's PCR COVID-19 laboratory test result collected on February 23, 2021 and resulted on February 24, 2021 shows, "SARS CoV 2 (COVID-19) Positive".

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S9999	Continued From page 4 R4's rapid COVID-19 laboratory test results collected on February 15, 2021 shows, "positive". The facility's floor plan shows that R1, R2, R3, and R4 are all on hallway with other residents that are negative for COVID-19. Each positive resident listed (R1, R2, R3, and R4) has a negative COVID-19 resident in between them and across the hall from them. Facility floor plan shows to get anywhere in the building (e.g. second floor, kitchen, therapy room) staff and residents have to walk through the hallways that have the positive COVID-19 residents. On March 3, 2021, at 9:56 AM, V1, epidemiologist at the local health department, stated the facility should be following CDC guidance by having a COVID-19 unit for any resident that is positive for COVID-19. V1 stated signage should be present to alert staff that resident is on isolation, and what type of isolation to identify proper PPE needed for cares. The doors of positive COVID-19 residents should also be closed. The facility's COVID-19 clinical monitoring and measures plan, COVID-19 enhanced measures and monitoring dated December 3, 2020 shows, "Note: enhanced measures and monitoring become effective when any employee presents with a positive COVID-19 antigen test or RT-PCR, OR a patient tests AND was not previously being cared for in transmission based (airborne-droplet) precautions prior to testing. Activation of COVID-19 airborne isolation unit (CAIU), if indicated: The CAIU is not a specialty unit. It is a dedicated location within the facility's physical plant which allows for cohorting of patients diagnosed with COVID-19 for the facilitation of quality care and the efficient	S9999		

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management of transmission based (airborne-droplet) precautions. Place any patient diagnosed in the facility with COVID-19 in transmission based (airborne-droplet) precautions ... Assign dedicated staffing to the CAIU (nursing, housekeeping, therapy) ..."

The CDC's preparing for COVID-19 in nursing homes last updated November 20, 2020 shows, "Identify space in the facility that could be dedicated to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19. Identify HCP who will be assigned to work only on the COVID-19 care unit when it is in use."

The CDC's responding to coronavirus (COVID-19) in nursing homes last updated April 30, 2020 shows, "Resident Cohorting: Considerations for establishing a designated COVID-19 care unit for residents with confirmed COVID-19. Determine the location of the COVID-19 care unit and create a staffing plan before residents or HCP with COVID-19 are identified in the facility. This will allow time for residents to be relocated to create space for the unit and to identify HCP to work on this unit ... Ideally the unit should be physically separated from other rooms or units housing residents without confirmed COVID-19. Depending on facility capacity (e.g., staffing, supplies) to care for affected residents, the COVID-19 care unit could be a separate floor, wing, or cluster of rooms. Assign dedicated HCP to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. HCP working on the COVID-19 care

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unit should ideally have a restroom, break room, and work area that are separate from HCP working in other areas of the facility. To the extent possible, restrict access of ancillary personnel (e.g., dietary) to the unit. Assign environmental services [EVS] staff to work only on the unit. If there are not a sufficient number of EVS staff to dedicate to this unit despite efforts to mitigate staffing shortages, restrict their access to the unit ... Place signage at the entrance to the COVID-19 care unit that instructs HCP they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms."

2. On March 1, 2021, at 10:14 AM, V1 Administrator, stated, that they are removing new admissions from isolation after 10 days. The facility tests the residents with rapid antigen tests and PCR test. If they are negative by the 10th day, they remove them from isolation. V1 stated this is the directions the facility received from corporate consultation. .

R2's electronic medical record shows he was admitted to the facility on February 10, 2021. His progress notes show on February 22, 2021 he was removed from contact/droplet isolation, 12 days after admission. R2 should have remained on contact/droplet isolation until February 24, 2021 per CDC's guidelines.

R2's COVID-19 laboratory test results collected on February 23, 2021 and resulted on February 24, 2021 show he was positive for COVID-19. These dates correlate to the 13th/14th day of what should have been isolation, per CDC's guidelines.

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S9999	Continued From page 7 The Illinois Department of Public Health (IDPH) Quarantine Guidance last updated January 14, 2021 shows, "Due to the risk of severe illness and congregate transmission, IDPH recommends the full 14-day quarantine period rather than the shortened options described above in congregate living settings with vulnerable populations, such as skilled care and correctional facilities." The CDC's preparing for COVID-19 in nursing homes last updated on November 20, 2020 shows "Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown. Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19 ... Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected." The CDC's responding to Coronavirus (COVID-19) in nursing homes last updated on April 30, 2020 shows, "Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19 ... Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic SARS-CoV-2-infected residents into the COVID-19 care unit. However, a single negative	S9999		

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S9999	Continued From page 8 test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE ... New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). Testing at the end of this period could be considered to increase certainty." (A)	S9999		