STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015523	A. BUILDING: _____ B. WING _____	C 03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS (GLEN ELLYN)	2 SOUTH 706 PARK BLVD GLEN ELLYN, IL 60137

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S 000	Initial Comments Investigation of Complaint Number 2371927/IL157248	S 000		
S9999	Final Observations Statement of Licensure Violation: 330.790a) Section 330.790 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. This Regulation was not met as evidenced by: Based on interview and record review, the facility failed to implement infectious disease prevention precautions for residents with suspected infectious disease as per facility policy. This applies to all 20 residents residing in the facility. The findings include: Resident Roster, dated 3/13/23, shows the facility census was 20 residents.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Census Report, dated 2/17/23, shows R1's hallway had 10 residents residing in the Berry Hall/Unit. The Census Report shows there were 10 additional residents residing in a separate XXX Hall/Unit. Review of facility Acute Gastroenteritis Outbreak Line List of Residents Ill With Diarrhea and/or Vomiting outbreak data, dated 2/17/23 to 3/14/23, shows R1 became symptomatic with vomiting and diarrhea on 2/17/23 and continued to have symptoms until 2/19/23. The record shows no other residents had infectious disease symptoms at that time. The record shows the following residents residing on YYY Hall became symptomatic with diarrhea and/or vomiting after R1 on the following dates: 1. R2 on 2/19/23 2. R3 on 2/19/23 3. R4 on 2/21/23 4. R6 on 2/23/23 Review of R1's clinical record progress notes showed R1 had multiple episodes of diarrhea on 2/18/23 and the physician ordered collection of a stool sample to determine if the cause of the diarrhea was C. diff (Clostridium difficile). The clinical record showed R1's stool sample was not sent to the laboratory until 2/22/23 and analysis showed R1 was negative for C. diff on 2/23/23. The clinical record fails to show R1 was placed on contact precautions or was isolated from non-symptomatic residents while having infectious disease symptoms and/or while being investigated for infectious disease. Review of R2's clinical record progress notes showed R2 had projectile emesis three times on 2/19/23 as well as diarrhea. The progress notes	S9999		

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S9999	Continued From page 2	S9999		

show R2 had a large amount of diarrhea on 2/21 and the notes show R2 received a physician order for collecting and testing R2's stool for C. diff and Giardia, and crypto. The progress notes show the stool sample was picked up on 2/22/23 and the results were negative on 2/23/23. The clinical record shows no indication R2 was placed on contact precautions while under investigation for infectious disease or was isolated from non-symptomatic residents while having infectious disease symptoms and/or while being investigated for infections disease.

Review of R3's clinical record progress notes showed R3 had 2/19/23 projectile emesis and nausea and two episodes of loose stools on 2/23/23. The progress notes show on 2/23/23, R3 received a physician order to collect stool for C. diff. Progress notes show on 2/25/23, R3 was participating in an activity held in the common area of the unit. The progress notes show the stool results for C. diff were negative but the facility was awaiting results for Norovirus. The progress notes show on 3/1/23 the facility was informed R3 was positive for Norovirus. The clinical record shows no indication R3 was placed on contact precautions while under investigation for infectious disease or was isolated from non-symptomatic residents while having infectious disease symptoms and/or while being investigated for infections disease.

Review of the staff outbreak data, dated 2/17/23 to 3/14/23, shows V3 (Marketing Director) became symptomatic 2/23/23 and nine staff subsequently became symptomatic between 2/23/23 and 3/14/23. Review of resident outbreak data shows R5 became symptomatic on 2/21/23 on the XXX Hall and subsequently a total of 12 additional facility residents (R7-R16)

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S9999	Continued From page 3 became symptomatic between 2/23/23 and 3/14/23. On 3/13/23 at 9:52 AM, V9 (Registered Nurse) stated the Norovirus outbreak began on YYY Hall when R1 became symptomatic and began vomiting and having several episodes of diarrhea. V9 stated R1 was "initially cohorted" by isolating the YYY Hall residents in YYY Hall but not isolating R1 to her room and away from asymptomatic residents. V9 stated no other residents on the hall having infectious disease symptoms at the time they kept the residents in the YYY Hall. V9 stated there were no attempts to keep R1 contained to her room and the residents in YYY Hall were able to mingle and eat meals together. V9 stated R1 was initially tested for C. diff (Clostridium difficile) and the results were negative. V9 stated staff were only using gloves and gowns when toileting R1 but at no other times when in contact with R1. At 2:32 PM, V9 (Registered Nurse) stated none of the YYY Hall symptomatic residents between 2/17/23 and 3/1/23 (R1, R2, R3, R4, R6) were isolated from the non-symptomatic residents in the hall. V9 stated on 3/1/23, only after receiving positive Norovirus lab results for residents at the facility, did the facility begin attempting to keep symptomatic residents in their rooms and away from non-symptomatic residents. V9 stated on 3/1/23, staff also began wearing gowns, gloves, and masks when in symptomatic resident rooms and in contact with the symptomatic residents and not only when toileting the symptomatic residents.V9 stated staff also began separately bagging symptomatic resident landry after 3/1/23. On 3/13/23 at 1:21 PM, V1 (Administrator) stated after R1 became symptomatic and was awaiting results of a C. diff lab, the facility kept all YYY Hall	S9999		

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S9999	Continued From page 4 residents together whether they were experiencing symptoms or not. V1 stated the facility did not initiate contact precautions with R1 when they suspected she had C. diff. of for any of the other symptomatic residents until the lab confirmed there was a resident positive for Norovirus at the facility. V1 stated there was no facility policy/procedure regarding the care of residents waiting for results of a C. diff lab. Facility Infection Control Manual, dated 2021, shows, "Upon identification of a potential outbreak, conduct an outbreak investigation. The objectives of any outbreak investigation are to describe the situation (what is happening), determine the etiology (where did the infection start), what is the agent, where is the source and what is the method of spread .... The next step is to stop the outbreak by isolating the infection and implementing preventive measures to prevent a reoccurrence .... The following control measures are considered during an outbreak investigation: Implement designated precautions ..., cohort patients/residents as appropriate with like symptoms based on Medical Director and local health department recommendations .... Norovirus associated illness typically begins after an incubation period of 12-48 hours and is characterized by acute onset of non-bloody diarrhea, vomiting, nausea, and abdominal cramping .... Preliminary Measures - Practices to implement when clusters are identified by awaiting confirmation include: Implement preliminary precautions - confine symptomatic patients/residents to rooms or group on affected units until information known, initiate contact precautions for symptomatic patients/residents ..., reinforce infection control principles including standard and contact precautions practices with employees ...."	S9999		

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S9999	Continued From page 5 Facility Infection Control Manual, dated 2021, shows Disease Specific Guidelines shows the facility was required to implement Contact and Standard precautions for residents suspected of Clostridium difficile. Facility Infection Control Manual, dated 2021, shows, "Practice Guidelines- Wear gloves for any interactions with patient or their environment... Wear gown when clothing anticipated to come in contact with the patient, environmental surfaces or items in room contaminated with organism. apply gown upon room entry and remove gown before leaving room..., clean and disinfect equipment between patients, limit transport and movement of patients outside of the room to medically necessary purposes..., provide private room with a dedicated bathroom preferred for patients with poor hygiene habits or who cannot be expected to assist in maintaining infection control practices, cohort patients with the same active infection. (B)	S9999		