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	IL6016810	A. BUILDING: _____ B. WING _____	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVONDALE ESTATES OF ELGIN	1754-1760 CAPITAL STREET ELGIN, IL 60124

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S 000	Initial Comments Annual Licensure and Certification.	S 000		
S9999	Final Observations Statement of Licensure Violations: (1 of 2) 300.610a) 300.696b)3) 300.696d)7)17) 300.696f)4) 300.1020a) 300.1020b) 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 Prevention and Control b) Written policies and procedures for surveillance, investigation, prevention, and control of infectious agents and healthcare-associated infections in the facility shall be established and followed, including for the appropriate use of personal protective equipment as provided in the Centers for Disease Control and Prevention ' s	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Guideline for Isolation Precautions, Hospital Respiratory Protection Program Toolkit, and the Occupational Safety and Health Administration ' s Respiratory Protection Guidance. The policies and procedures must be consistent with and include the requirements of the Control of Communicable Diseases Code, and the Control of Sexually Transmissible Infections Code. 3) Facility activities shall be monitored on an ongoing basis by the Infection Preventionist to ensure adherence to all infection prevention and control policies and procedures. d) Each facility shall adhere to the following guidelines and toolkits of the Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, Agency for Healthcare Research and Quality, and Occupational Safety and Health Administration (see Section 300.340): 7) Infection Control in Healthcare Personnel: Infrastructure and Routine Practices for Occupational Infection Prevention and Control Services 17) Guidelines for Environmental Infection Control in Health-Care Facilities f) Infectious Disease Surveillance Testing and Outbreak Response 4) Upon confirmation that a resident, staff member, volunteer, student, or student intern tests positive with an infectious disease, or displays symptoms consistent with an infectious disease, each facility shall take immediate steps to prevent the transmission by implementing practices that include but are not limited to	S9999		

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S9999	Continued From page 2 cohorting, isolation and quarantine, environmental cleaning and disinfecting, hand hygiene, and use of appropriate personal protective equipment. 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 Regulations were not met as evidence by: The facility failed to implement acceptable standard of infection control practices regarding the following: A. Based on observation, interview, and record review, the facility failed to follow facility policies, failed to identify and ensure a resident (R362) with diagnosis of Candida Auris (highly contagious fungal rash infection) and with drainage from a non-contained open wound rash was placed on contact precautions, failed to prevent cross contamination during wound dressing change and while removing	S9999		

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contaminated medications from the isolation room, failed to utilize dedicated medical equipment in an isolation room, and failed to educate staff and family regarding necessary contact precautions and use of protective equipment.

This applies to 30 of 30 residents (R1, R18, R20, R28, R39, R40, R47, R48, R50, R53, R54, R57, R117, R118, R119, R120, R121, R122, R123, R124, R125, R126, R127, R128, R129, R141, R361, R362, R363 and R354) reviewed for infection control.

The findings include:

The EMR (Electronic Medical Record) showed that R362, a 92-year-old, was admitted to the facility on 6/19/23. R362's diagnoses included Candida Auris (Per the Centers for Disease Control and Prevention dated December 27, 2022: a fungal infection that presents a serious global health threat, often a multi drug resistant infection that can cause an outbreak in a facility settings), syncope and collapse, epilepsy, congestive heart disease, chronic embolism, diabetes, atrial fibrillation, non-pressure chronic ulcer of the right calf, transient ischemic attack, protein calorie malnutrition, and thrombosis.

The MDS (Minimum Data Sheet), dated 5/23/23, shows R362's cognition was moderately impaired, and R362 required limited to extensive assistance from staff for ADLs (Activities of Daily Living) including hygiene, transfers, toileting, dressing and bed mobility.

The transfer order dated 6/19/23, shows that R362 was transferred to the facility with a physician order, dated 6/18/23, for contact

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S9999	Continued From page 4 precautions due to Candida Auris to the right axilla. On 6/27/23 at 3:01 PM, V6 (Registered Nurse-Admission Nurse) stated that R362 was admitted to the facility with an order of contact precautions due to Candida Auris to the right axilla. V6 stated he "overlooked" the order of contact precautions and failed to transcribe it into R362's admission orders to the facility. This resulted in R362 not being placed in contact isolation precautions. V6 further said that no one screened resident' clinical needs prior to admission except when the resident was already in the facility, and this had delayed placing R362 on contact isolation precautions. V6 also said it was 3 days that R362 was not on contact isolation precautions, and it was only when V16 (Kane County Health Department) had called and informed the facility that R362 was positive for Candida Auris and was on their surveillance list. V6 stated V16's call had prompted the facility to place R362 on contact isolation precautions. V6 stated he should have looked at the transfer records thoroughly and it would help if referral documentation was screened by clinician prior to resident' admission so the appropriate infection control would be timely implemented. V6 stated no one at the facility screened the admission referral except the admitting nurse which was V6 who stated he overlooked the resident's infection control precautions order. V6 stated if he had identified R362 as needing to be placed on contact precautions, he would have referred R362 to V7 (Infection Control Preventionist Nurse) to ensure correct management of the infection control precautions. On 6/27/23 at 1:05 PM, V16 (Kane County Public Health) stated she informed the facility that R362	S9999		

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was on their list for surveillance/tracking due to positive diagnosis of Candida Auris of the right axilla.

On 6/28/23 at 11:40 AM, V9 (Attending Physician/ Medical Director) stated that a resident's transfer order should be carried out and be continued when transferred to the admitting facility which includes any orders for transmission-based precautions. V9 also stated he was made aware of R362's contact isolation precautions due to Candida Auris recently on 6/22/2023 when Kane County Public Health had called the facility for tracking. V9 stated if R362 has drainage and flaky substances from the axilla, then R362 is considered contagious and able to transmit Candida Auris and therefore strict contact precautions should be continued. V9 stated the facility required guidance to manage this highly contagious disease.

On 6/26/23, at 10:00 AM, during the initial tour with V10 (Registered Nurse), it was observed at the entrance of R362's door that there was a sign which showed "Contact Isolation." V10 stated, "The contact isolation sign was a mistake." V10 stated "(R362) is only on Enhanced Barrier Precautions due to a wound on her buttocks related to Moisture Associated Skin Damage (MASD)." V10 stated only gloves were required to enter the room. V10 and the surveyor entered R362's room wearing only gloves. Inside room of R362, there was no dedicated medical equipment such as stethoscope, sphygmomanometer, and thermometer. V10 said that the medical equipment used for R362 is the same medical equipment used and shared with other residents on the third floor. R362 was lying in bed, awake, confused. There was an open box of Debrox eardrop medication on the bed, on R362's left

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side near her left hand and left thigh. V10 took the open eardrop medication and stated, "(R362) cannot administer this because she is confused." V10 picked up the medication, removed her gloves, and took the mediation out of R362's room. V10 continued to hold the Debrox medication with her bare hands and walked in and out several resident rooms including R361, R47, R118, R39 and placed it on top of their beds, overbed tables, and nightstands. V10 then took the medication to the nursing station, placed it on the nursing station countertop, and called a physician for orders. V10 then proceeded to place the medication on top of the West Unit medication cart. V13 (R362's daughter) and V12 (R362's son) were in R362's room and they were not wearing any PPE (Personal Protective Equipment). V13 stated she had not been provided any education regarding R362's infection, was not aware she needed to wear any PPE in the room, and V13 only understood R362 has rashes on the axilla. V13 also said no one provided education regarding handling R362's soiled laundry as V13 does R362's personal laundry.

On 6/26/23 at 3:00 PM, the EMR was reviewed. During the review, the surveyor had identified that R362's current POS (Physician Order Sheet) for the month of June 2023 showed a physician order dated 6/22/2023 for contact isolation precautions due to Candida Auris of the right axilla.

On 6/26/23 at 3:45 PM, surveyor verified with V10 regarding R362's current isolation precaution. V10 said she made a mistake and thought that R362 was on Enhance Barrier Precaution. In addition, V10 was not observed providing education to V12 and V13 regarding use of PPE,

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S9999	Continued From page 7 and V12 and V13 were seen going in and out of R362's room. On 6/26/2023 at 3:45 P.M., V18 (CNA/Certified Nurse Assistant) said she does not know what kind of precaution that R362 was on. On 6/27/23 at 4:30 PM, V7 (Infection Control Preventionist) stated he did not receive information from V6 regarding R362 being admitted with orders for isolation precautions. V7 stated if he had received notice R362 had a diagnosis of Candida Auris he would have placed R362 on isolation precautions and would have referred R362 to the Infectious Disease specialist for proper management. V7 stated R362's infection was a not a contained wound due to the blood that was oozing from the infected area, right axilla, and that the axilla still has a flaky substances from the rash. V7 stated that "(R362) has symptoms of oozing blood and flaky substances from the infected side (right axilla and under breasts), this indicates the presence of an active infection is still ongoing and strict contact isolation precautions should be maintained." V7 stated R362 was placed on "strict contact isolation precautions as of 6/27/23 at 3:33 PM." V7 explained that strict contact precautions meant that R362 was not to be removed from the room for therapies and all services should be performed inside her room. V7 further said that there should be dedicated medical equipment such as a thermometer, stethoscope, and sphygmomanometer, and they should be kept inside R362's room to ensure no occurrence of cross contamination. The skin admission assessment dated 6/19/2023: -right axilla with erythema moisture associated skin damage with dressing of less than 25%	S9999		

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saturation.
-6/20/2023:
- right axilla fungal rash, and bilateral breasts fold with rashes. The assessment also shows that right axilla skin was macerated, fungal rash noted under bilateral breasts folds.
-6/22/2023: fungal rash under right axilla noted with erythema and drainage.
-6/26/2023: right axilla Candida Auris, right axilla noted with decreased erythema (skin persistent redness irritation), papule (a raised area of skin tissue that is an inflamed bumps in the skin that might suggest skin condition that possible signs of undelaying skin condition/infection).

On 6/26/23 at 5:11 PM, V12, and V13 were in R362's room with V18. They were not wearing gloves and gowns. V18 was leaning against R362's bed with no PPE talking with the family. V18 exited the room and stated she was aware that she should have worn PPE. V12, V13 and V18 stated they had not been provided information about Candida Auris, and how they should handle R362's personal laundry.

On 6/26/2023 at 3:52 P.M., V19 (LPN/License Practical Nurse) said R362's family goes in and out of R362's room and does not wear PPE. V19 also said that R362's is on contact precaution and that anyone entering R362's room should wear PPE.

On 6/27/2023 at 4:45 P.M., V8 (Housekeeping/Laundry Department) said that R362's linens are washed at the facility. V8 also said that R362's personal clothing is handled by the family. V8 added that she did not provide education to R362's family on how to properly disinfect soiled clothing to prevent cross contamination. V8 said "it is up to nursing to do

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S9999	Continued From page 9 that." On 6/27/2023 at 11:43 A.M. R362 was observed for wound dressing change and skin observation. V3 (LPN/Wound Care Nurse) and V10 (CNA) did the wound dressing change. R362 was lying in bed, awake and alert with bouts of confusion. R362 said "It is itchy around my breasts, under my breast and my armpits and I sometimes scratch it." V12 was present in the R362's room, wearing a pair of gloves. V12 said he was informed by V13 as of 6/26/2023 to wear gloves only when entering R362's room. Prior to start of dressing change, V5 (CNA) was asked when was the last time R362 was provided skin care. V5 said that "this morning at 7:00 A.M. I gave her a bed bath. I noticed a lump of dried blood on the creases of (R362's) right axilla and accumulation of flaky substance around her axilla and underneath her breasts. The wound dressing change observation were as follows: -V3 said that R362 has a rash under breasts, right axilla, left hip skin tear and MASD to the left buttock and sacrum. V3 gathered the following treatment supplies: Gathered supplies: -Nystatin powder -Hydrocolloid x2 -Xerofoam dressing -Bordered gauze dressing -Skin prep pads (times 2) At 11:43 AM, entered room, V3, V10 and surveyors entered R362's room with PPE on. R362 was lying in bed. R362 said she complains of itchiness to her right axilla from warm clothes. -V10 used disinfectant wipe to clean the over the bed tray table, and bath towel was placed on table, then the dressing supplies were put on the table. V10 had pulled down R362's blanket and pulled	S9999		

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S9999	Continued From page 10 towards feet and upper shirt was pulled up exposing R362's upper chest to feet. R362's right breast was observed with 4 raised, fluid filled skin papules that were yellowish in color. The size was approximately 0.5 cm x 0.5 cm in diameter. V3 said the raised skin are pimples and with yellowish fluid blisters. The raised skin was surrounded with flaky yellow substances. V3 said the largest papule near the skin fold "like a pimple with a white head." R362's right forearm was slightly pulled away by V10 to expose R362's right axilla. The right axilla has an open area and creases and fresh red blood combined with serosanguinous drainage coming out of the right axilla. V3 measured R362's right axilla and measurement showed 5.5 cm x 7 cm (L x W) with an open area measuring 1.5 cm x 1.0 cm. R362's left breast- one area close to the medial chest measuring ¼ inch raised area that is red and appears to be scabbed. Red rash area under breast described as "flaky" per V3. V3 changed gloves after lifting breast to arm to look at axilla areas. Placed the box of gloves on R362's bed to grab new gloves to put on. There was no hand hygiene after removing gloves and putting on new gloves. After both staff removed new gloves from the box, the box was removed from the bed to the dresser in the room. R362 right shin has a dry flaky rash. R362's left rash on anterior right shin extends from the ankle to below the knee and extends to the posterior calf. R362 was turned onto her right side to make left hip visible. Left hip showed a skin tear measuring 1.1 cm x 0.5 cm. Left hip was cleaned with saline by V3, she then removed gloves, no hand hygiene, new gloves, dressing applied. After done applying dressing, V3 had removed gloves, washed hands with soap and water, put on new gloves.	S9999		

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S9999	Continued From page 11 R362's incontinence brief was opened by V3 and V10. R362 was turned to her right side, two dressings were noted to the resident's left buttock and sacral area. R362's incontinence brief was noted to be wet and there was a small smear of stool. V3 said there was no stool, and surveyor pointed out the stool that was noted in between buttocks. V3 had removed the two dressings (sacral and left buttock) before providing incontinence care. There were two open wounds that were exposed to contaminant (urine and stool). V10 went to bathroom and filled 2 basins, one with water and body wash and other basin with plain warm water. V3 followed V10 into the bathroom and was heard talking Spanish to the V10, when V10 came from bathroom and went to the right side of bed with R362 facing her. V10 took a washcloth with water and body wash, V10 leaned over R362, V10's thighs, upper legs and abdomen were in direct contact with R362's when she leaned over the resident. V10 was wiping R362's stool from the rectal area, from front to back towards the open sores which were exposed, and this had open to cross contamination of the open wounds. Surveyor asked V10 to come around the bed to the side where she would be able to see what she was doing. V3 measured R362's wound on left buttock and the measurement were 1.0 cm x 0.5 cm x 0.0. Wound on sacral area 1.5 cm x 1.0 cm, x 0.0. V3 continued to clean R362's left buttock was cleaned with saline and applied skin prep and hydrocolloid dressing. V3 then proceeded with R362's sacral wound, cleaned with saline, skin prep applied, and hydrocolloid dressing. During this wound dressing observation, hand hygiene was not consistently implemented, only	S9999		

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one time V3 was observed with hand hygiene despite multiple changing of gloves after removing contaminated dressings. V10 never did hand hygiene during the process.

On 6/29/2023 at 11:30 A.M., V20 (Wound Care Physician) said that regarding Candida Auris, a group of specialists including epidemiologist guidance should be sought to ensure proper care and management of the infection.

On 6/28/2023 at 1:25 P.M., V1 (Administrator) and V2 (Director of Nursing) said that staffing on the third floor were scheduled and assigned permanently as possible on the third floor. R362 resides currently on the third floor. V1 and V2 said that third floor currently housed 30 residents including R362.

There were multiple facility's policies that were reviewed with V2 on 6/29/2023 at 1:30 P.M.
1. The facility's admission policy dated January 2011 shows: "Before or at time of admission, the resident's attending physician must provide facility with information needed for immediate care of the resident ...Acceptance of residents with certain conditions or needs may require authorization or approval by Medical director Administrator and DON ... The Administrator through the admission department shall assure that the resident and facility follow applicable admission policies.
2. The undated facility's admission check list showed that it included checking to ensure any isolation was needed.
3. The facility's Physician Orders-Medication & Treatment policy dated 11/2027 shows that "1. The physician's orders shall be entered or transcribed in the resident's medical records. 2. Medications and Treatments shall be transcribed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016810	A. BUILDING: _____ B. WING _____	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVONDALE ESTATES OF ELGIN	1754-1760 CAPITAL STREET ELGIN, IL 60124

(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 13 in the resident's medical records when ordered upon admission ..." 4. The facility's Admission Policy of Residents of Communicable Disease shows ensure to provide appropriate medical and nursing care .... Prior to or upon admission the infection control nurse will assess the following infection risk for each admission ...A resident who is transferred to an acute facility with infection ... should be reviewed prior to admission the facility. 5. The facility's policy dated 6/21/2023 regarding Transmission Based Precautions policy showed that the purpose of this policy is to summarize best practices for the use of transmission-based precaution to assist with decision making regarding the placement of residents with organisms of concern. ...XDRO (Extensively Drug Resistant Organisms) refers to organisms that being entered into the XDRO registry and conditions of these infections included but not limited to Candia Auris ... Transmission based precautions are for patients known or suspected to be infected or colonized with infectious agents including will require additional control measures to effectively prevent transmission. When implementing TBP (Transmission Based Precautions) XDRO, contact precautions should be implemented with drainage that cannot be contained. 6. The facility's policy dated 1/2023 for Candida Auris shows that facility will implement the procedures for infection prevention and control for Candida Auris ...Have healthcare personnel and visitor who enter the isolation room should have PPE donned prior to entering room including gown, gloves, and facial mask in case of unexpected contamination from the source of infection. When leaving the isolation room, removed PPE, dispose to appropriate receptacle,	S9999		

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S9999	Continued From page 14 wash hands thoroughly. The soiled should be handled with the use of recommended disinfectant to prevent cross contamination. If family does laundry of the infected residents, should be given education how to handle soiled clothing using appropriate disinfectant. 7. The facility's wound care policy dated 11/2025 showed that staff should wash hands thoroughly before the dressing change, maintained clean barrier field, wash hands/hand hygiene after removing gloves. Do not cross contaminate by exposing open wound with no dressing with contaminants such as bowl, urine and bodily fluids. (A) Statement of Licensure Violations (2 of 2) 300.700a) 300.700b)1)2)3) Section 300.700 Testing for Legionella Bacteria a) A facility shall develop a policy for testing its water supply for Legionella bacteria. The policy shall include the frequency with which testing is conducted. The policy and the results of any tests and corrective actions taken shall be made available to the Department upon request. (Section 3-206.06 of the Act) b) The policy shall be based on the ASHRAE Guideline "Managing the Risk of Legionellosis Associated with Building Water Systems" and the Centers for Disease Control and Prevention's" Toolkit for Controlling Legionella in Common	S9999		

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S9999	Continued From page 15 Sources of Exposure". The policy shall include, at a minimum: 1) A procedure to conduct a facility risk assessment to identify potential Legionella and other waterborne pathogens in the facility water system; 2) A water management program that identifies specific testing protocols and acceptable ranges for control measures; and 3) A system to document the results of testing and corrective actions taken These Regulations were not met as evidence by: Based on interview and record the facility failed to follow their Water Management Program and test yearly for the Legionella bacteria. This applies to all 77 (Census on form 672) residents residing in the facility. The findings include: The facility provided their "Water Management" binder. Review of the binder showed the facility water had been tested for the Legionella bacteria in September 2018. On June 29, 2023 at 12:46 PM V28 (Maintenance Director) and V29 (Assistant Maintenance Director) said they test the water temperatures in the building, but they are not testing the water for Legionella and do not think there is a company coming in to do it. On June 29, 2023 at 1:02 PM, V1 (Administrator) said they do not have a company coming to do	S9999		

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S9999	Continued From page 16 annual testing. Facility provided policy dated October 2018, titled "Water Management Program Policy and Procedure" showed "Policy: The facility will implement the Water Management Program to reduce the risk for Legionnaire's disease associated with the building water system and devices, reduce the growth and spread of Legionella bacteria in the facility, and to identify areas or devices in the facility where Legionella might grow or spread to people so the facility can reduce that risk.....4. Control measures and Corrective Actions: .....C. The following but not limited to are the areas that will be routinely checked: Quality of Water: On a quarterly basis a culture sampling and analysis shall be performed during the first year of the program and annually thereafter (and PRN (as needed) basis). (C)	S9999		