

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/27/2020
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NAME OF PROVIDER OR SUPPLIER ROLLING HILLS MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3615 16TH STREET ZION, IL 60099
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S9999	<p>Continued From page 1</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements were not met evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to implement infection control policies and recommendations from the local health department regarding isolation of COVID-19 residents; regarding cohorting of</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>COVID-19 residents; and proper Personal Protective Equipment (PPE) usage. This failure has the potential to infect high risk residents with COVID-19 and spread the disease to COVID-19 negative residents. This applies to 6 of 15 residents (R2, R4, R6, R8, R11, and R12) reviewed for infection control practices in the sample of 15.</p> <p>The findings include:</p> <p>1. The facility's COVID-19 Resident Line Listing, provided on 10/20/2020, showed 29 residents were in isolation for positive COVID-19 test results. The report also showed that 6 residents died within days after being diagnosed with COVID-19.</p> <p>On 10/20/2020 at 11:30 AM, R1 and R2 were seen in the same room together and both of their names were on the door. R2 was in her wheel chair with her lunch in front of her. R1 was in her wheelchair, near the window, with her lunch as well. Their door was not shut. The curtain was pulled halfway, and residents were within sight of each other.</p> <p>R2's COVID-19 test results, which were collected on 10/13/2020 and reported on 10/15/2020, showed the Result to be "Not Detected." The lab result showed, "A Not Detected (negative) test result for this test means that SARS-CoV-2 RNA was not present in the specimen above the limit of detection."</p> <p>R1's COVID-19 test results for the same dates as R2, showed the result to be "Detected." The lab test showed, "A Detected result is considered a positive test result for COVID-19. This indicates</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>that RNA from SARS-CoV-2 was detected, and the patient is infected with the virus, and presumed contagious." (R1 and R2 were together in the same room for 5 days after the facility was aware of positive test results)</p> <p>The facility's Room/Bed list showed R1 and R2 were roommates.</p> <p>2. On 10/20/2020 at 11:32 AM, R4 was observed in her room. R4's roommate, R3, was not in the room and R3's bed was stripped.</p> <p>On 10/21/2020 at 3:53 PM, V5 Infection Preventionist stated, R3 was sent to the hospital on 10/17/2020 for a fever, and an oxygen saturation of 88%. V5 stated she was admitted to the hospital with pneumonia and she was COVID-19 positive.</p> <p>R3's COVID-19 test, collected on 10/13/2020 and reported on 10/16/2020 showed the result to be "Detected."</p> <p>R4's COVID-19 test, collected on 10/13/2020 and reported on 10/15/2020 showed the result to be "Not Detected."</p> <p>R3's 10/15/2020 Nursing Notes showed, she was given 650 milligrams of Acetaminophen for a fever at 7:42 AM. (Acetaminophen lowers a persons fever)</p> <p>R3's Vital Signs showed a temperature of 100 degrees Fahrenheit on 10/15/2020 at 1:38 AM.</p> <p>R3's 10/17/2020 8:10 PM Nursing Note showed, "...Resident developed a temp of 100.7 around 17:45 (5:45 PM) and had a SpO2 at 88%</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>(Oxygen saturation percentage). Resident noted with heavy congestion, and phlegm in oral airway. Suctioned performed...copious amounts of sputum suctioned..." (R4 was her roommate during this time and had tested negative for COVID-19)</p> <p>The Centers for Disease Control and Prevention (CDC) website titled Preparing for COVID-19 in Nursing Homes updated 6/25/2020 showed, "Evaluate and Manage Residents with Symptoms of COVID-19. Ask residents to report if they feel feverish or have symptoms consistent with COVID-19. Actively monitor all residents upon admission and at least daily for fever (T=100.0 degrees Farenheit) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions as described below."</p> <p>The facility's Room/Bed list showed R3 and R4 to be roommates.</p> <p>3. On 10/20/2020 at 2:20 PM, R5 and R6 were seen in the same room together. R5 and R6's names were on the door. R5 was sleeping in her bed closest to the door. R6 was in her bed closest to the window. The door to R5 and R6's room was open to the hallway.</p> <p>R5's COVID-19 test, collected on 10/13/2020 and reported on 10/15/2020 showed, the result to be "Detected."</p> <p>R6's COVID-19 test, collected and reported the same dates as R5 showed, the result to be "Not Detected."</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>The facility's Room/Bed list showed R5 and R6 to be roommates. (5 days after positive test results)</p> <p>4. On 10/20/2020 at 2:10 PM, R7 and R8 were seen in the same room together. R8 was nearest the door sitting in her wheelchair and R7 was nearest the window working on a puzzle; neither resident wearing a mask. The door to R7 and R8's room was open.</p> <p>On 10/20/2020 at 2:10 PM, R8 stated, "No one asked me to move rooms...No one asked me to move because of COVID, if they did I would have to think about it."</p> <p>On 10/21/2020 at 12:30 PM, V6, R8's Power of Attorney stated, she was never contacted about moving R8 or R8 refusing to move. V6 said "I would remember that." V6 said, had she been notified that R8 had refused to move she would have attempted to persuade her to move.</p> <p>R7's COVID-19 test, collected on 10/13/2020 and reported on 10/15/2020 showed, the result to be "Detected."</p> <p>R8's COVID-19 test, collected and reported the same dates as R5 showed, the result to be "Not Detected."</p> <p>The facility's Room/Bed list showed R7 and R8 to be roommates. (5 days after positive test results)</p> <p>5. On 10/20/2020 at 2:25 PM, R9 and R12 were observed in a 4 bed room and to be in the beds closest to the door. R11's and R10's beds were not visible from the door due to the curtains being pulled; R11 and R10 were not visible. Outside</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>the room, R9-R12's names were on the door. R9 was in bed and R12 was sitting at the edge of the bed attempting to get up to the bathroom on her own.</p> <p>On 10/21/2020 at 3:53 PM, V5 Infection Preventionist stated, R11 is in the facility and is roommates with R9 and R12. V5 stated, R10 was sent to the hospital on 10/16/2020 due to an X-ray showing atypical pneumonia. V5, said R10 was admitted to the hospital for pneumonia.</p> <p>R9's COVID-19 test, collected on 10/13/2020 and reported on 10/15/2020 showed the result to be "Detected."</p> <p>R10's COVID-19 test, as documented on the facility Resident Line Testing showed she was "Positive" and the facility was aware on 10/15/2020.</p> <p>R11's COVID-19 test, collected on 10/13/2020 and reported on 10/16/2020, showed the result to be "Not Detected."</p> <p>R12's COVID-19 test, collected on 10/13/2020 and reported on 10/15/2020, showed the result to be "Not Detected." (R11 and R12 cohorted with two COVID positive residents.)</p> <p>The facility's Room/Bed list showed R9, R10, R11, and R12 to be roommates.</p> <p>On 10/20/2020 at 1:05 PM, V5 stated she was aware that COVID-19 positive residents should not be roomed with COVID-19 negative residents and the roommates of COVID-19 positive residents she be separated and monitored for signs and symptoms of COVID-19.</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>On 10/21/2020 at 9:15 AM, V4 Lake County Contagious Disease Program specialist for Long-Term Care stated she had spoken with V5 on 10/15/2020. V4 said they had discussed the plan of action after receiving the COVID-19 positive results. V4 said, "We discussed how important it was to cohort staff and residents on the COVID unit to try and prevent the further spread of COVID. We would never make that recommendation to keep a COVID positive resident with a COVID negative resident. That would be the definition of high risk exposure due to a confined room, no mask, and for greater than 15 minutes."</p> <p>On 10/21/2020 at 12:58 PM, V3 Facility's Medical Director stated, "It's an obvious, 'No,' they should not have a positive roommate, with a negative roommate." V3 said, "If a resident tests positive and another tests negative then they should be segregating the two, to try and preserve the lack of infection in the negative resident." V3 said complications of COVID-19, besides mortality, include increased clotting which can lead to strokes, and heart attacks; pneumonia; exacerbation of other health conditions such as heart failure; and "if nothing else they come out the other side much weaker and drained."</p> <p>The facility wide testing conducted on 10/20/2020 and reported to the facility on 10/22/2020 showed R4, R6, and R12 were now "Detected" or positive for COVID-19.</p> <p>The Centers for Disease Control and Prevention (CDC) website titled Responding to COVID-19 Considerations for the Public Health Response to COVID-19 in Nursing Homes showed, "If the resident is confirmed to have COVID-19, regardless of symptoms, they should be</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>transferred to the designated COVID-19 care unit. Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents..."</p> <p>The facility's COVID-19 Testing Plan and Response Strategy showed, "If patents have been screened and their testing is Positive for COVID-19...Private room or cohort with another symptomatic/positive patient."</p> <p>6. On 10/20/2020 during initial tour of the facility, COVID-19 positive residents and COVID-19 negative residents were observed on all 4 wings of the facility. COVID-19 positive rooms were seen with their door open to the hallway. The same staff were observed caring for both COVID-19 positive and COVID-19 negative residents. No plastic boundaries were observed, PPE requirements were not posted on resident doors, no specific COVID-19 unit was observed. Staff were observed sitting in alcoves on the units.</p> <p>On 10/20/2020 at 2:25 PM, V7 Certified Nursing Assistant entered R9-R12's room to assist R12 (A COVID-19 positive room.)</p> <p>On 10/20/2020 at 2:30 PM, V7 stated she cares for both COVID-19 positive and negative residents on her hallway.</p> <p>On 10/20/2020 at 1:05 PM, V5 Infection Preventionist stated, "We wanted to cohort the residents but the struggle was staffing." V5 said, the facility did not receive all of the test results until Friday, 10/16/2020. V5 stated, "The DON (Director of Nursing) and I discussed what we were going to do on Friday we were going to have</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>to move a lot of them..." (Many COVID-19 results were available on 10/15/2020 (Thursday) as of 10/20/2020, 5 days later, COVID-19 residents and staff had not been cohorted.)</p> <p>On 10/21/2020 at 9:15 AM, V4 Lake County Contagious Disease Program Specialist for Long-Term Care stated she had spoken with V5 on 10/15/2020. V4 said, "We discussed that they needed to move the COVID positive residents to one wing; I believe we discussed the 400 wing, and move the roommates of the COVID positive to quarantine wing and keep close monitoring on them. I think we picked 400 wing because that was where most of the positives were. Our advice would be to leave COVID positive on that wing and to move the COVID negative to a quarantine wing with close monitoring. We discussed how important it was to cohort staff and residents on the COVID unit to try and prevent the further spread of COVID."</p> <p>On 10/21/2020 at 12:58 PM, V3 Facility's Medical Director stated, "The last I heard they did have a COVID unit, and when they had residents who were positive on the same unit as negative residents they were putting plastic over the door to contain the spread."</p> <p>On 10/20/2020, observations made during initial tour, showed no plastic sheeting over resident door ways.</p> <p>The facility's COVID-19 Testing Plan and Response Strategy Revision date 6/9/2020 showed, "Focus on decreased staff rotation and cohort staff who work with symptomatic residents whenever possible...Identify additional isolation rooms limiting to single unit if possible, cohort like-cases if necessary (e.g., influenza with</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>influenza, COVID-19 with COVID-19)..."</p> <p>On 10/21/2020 at 3:53 PM, V5 Infection Preventionst stated all of the residents who were negatvie for COVID-19 and were living with COVID-19 positive roommates, had been roommates as of 10/15/2020 or earlier.</p> <p>7. On 10/20/2020 at 11:25 AM, V8 Certified Nursing Assistant (CNA) was observed on the 300 hall. V8 was wearing a face shield, N95, surgical mask over N95, washable gown, and a disposable gown over the washable gown. V8 entered 3 COVID-19 positive rooms, one of the rooms she left and entered a second time. Upon leaving the COVID-19 positive rooms, V8 did not remove her disposable gown. The 300 hall also houses COVID-19 negative residents.</p> <p>On 10/20/2020 at 11:30 AM, V8 stated she only changes her disposable gown after she is finished caring for the COVID-19 residents. V8 stated she does care for negative and positive in the same day. V8 stated there has been a shortage of disposable gowns at the facility.</p> <p>On 10/20/2020 at 1:05 PM, V5 stated, the facility has enough disposable gowns to meet their needs and has not had difficulty obtaining them. V5 said, staff should change their disposable gowns after caring for COVID-19 residents.</p> <p>The Centers for Disease Control and Prevention (CDC) website titled Responding to COVID-19 Considerations for the Public Health Response to COVID-19 in Nursing Homes updated June 25, 2020 showed, "Ensure the resident is isolated and cared for using all recommended COVID-19 PPE. Place the resident in a single room if possible pending results of SARS-CoV-2 testing."</p>	S9999		
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S9999	<p>Continued From page 11</p> <p>Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated 7/15/2020 showed, "The PPE recommended when caring for a patient with suspected or confirmed COVID-19 includes the following: Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use."</p> <p>" B"</p>	S9999		