STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146076	A. Building B. Wing	06/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Clinton	1 Park Lane West Clinton, IL 61727

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 34058 Based on observation, interview, and record review, the facility failed to follow CDC (Centers for Disease Control and Prevention), CMS (Centers for Medicare and Medicaid Services), and IDPH (Illinois Department of Public Health) guidelines and facility policy for prevention of communicable disease including SARS-CoV-2 (human corona virus 2019, Covid-19) by failing to wear appropriate respiratory masks while providing care and services to residents during a Covid-19 outbreak within the facility. This failure effects six residents (R2, R3, R7, R8, R13, and R14) out of 12 reviewed for infection control on the sample of 14. Findings include: The CDC Guidelines for Covid-19 in Nursing Homes dated (updated) 2/22/22 documents an outbreak within a Long-Term Care facility is defined when 1 or more residents or facility staff are confirmed positive for Covid-19. These same guidelines document Long Term Care facility staff wear an N95 or higher-level respirator within the facility during a facility outbreak. The CMS Infection Prevention, Control, and Immunizations, revised 4/2022, documents an outbreak within a Long-Term Care facility is defined when 1 or more residents or facility staff are confirmed positive for Covid-19. This same Infection Prevention and Control documents facility staff wear an N95 or higher-level respirator within the facility during a facility outbreak. The Illinois Department of Public Health Guidance for Nursing Homes updated 3/22/22 documents an outbreak in a Nursing Home is defined when 1 or more residents or staff members are confirmed positive for Covid-19 and staff wear N95 respirator while inside the facility. The facility policy Covid-19 dated (revised) 1/19/22 documents, The Infection Control Program at this facility recognizes (Covid-19) as a highly contagious virus and has a focus to reduce the risk of unnecessary exposures among residents, staff, and visitors. Measures are based on guidance from the CDC, CMS, and state and local authorities. This same policy documents, All employees must wear a well-fitted face mask when in resident care areas. Other PPE (Personal Protective Equipment) may be required. On 6/22/22 at 8:40 am, V3 (Admissions Coordinator) stated, We do have one current resident with Covid, I am not exactly sure how many staff currently without looking it up. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Throughout the survey on 6/22/22, 6/23/22, and 6/24/22, there was an 8.5 inch by 11 inch paper sign at the front door of the facility with a red octagonal STOP symbol, documenting STOP, We have Covid in our building, please wear proper PPE while in our building. There was further signage in the form of brightly colored orange 8.5 inch by 11-inch paper located at the double doors in the front foyer area into the residential areas documenting, Staff PPE requirements as of 3/28/22: Nurses and CNAs (Certified Nursing Assistants) and anyone not boosted (having not received a booster vaccine following the primary series vaccines)- N95 mask. All staff who enter resident rooms with a resident present- N95 mask. General areas if boosted- surgical mask. WWW Hall (isolation hall) all PPE, gown/ gloves/ N95/ eye protection (goggles or face shield). There were identical signs also posted at the entrance to each of the facility's XXX Hall, YYY Hall, and ZZZ Hall. In addition, there was an identical sign posted at the midpoint of the YYY Hall which was the entry to the facility's memory care unit. On 6/22/22 at 9:42 am, V5 (Housekeeper) stated, We do have 1 resident positive with Covid right now. The facility's list, Covid Positive Residents May-June, documents 1 current resident positive case of Covid (R4), with 10 other residents who had been resolved since 5/1/22. The facility's Tracking List of Positive Staff dated for May and June 2022, documents a total of 5 staff members currently positive with Covid-19 (tested positive 6/14/22 or later), and 16 other staff who had resolved since 5/1/22. On 6/22/22 at 12:46 pm, V1 (Administrator) confirmed the number of staff and residents who had been positive since 5/1/22. 1) On 6/22/22 at 9:50 am, V6 (Physical Therapy Assistant) wearing a medical (surgical) type mask, entered the room of R2 and R3. V6 was working in direct contact with R2 providing therapy services wearing the medical mask and R2 being unmasked. R3, also unmasked, was in the bed directly adjacent to R2's bed. On 6/22/22 at 9:50 am, V6 stated, As far as I know, I am only supposed to wear an N95 if I am working with a resident who is actually positive for Covid. 2) On 6/22/22 at 9:50 am, V8 (Housekeeper) wearing a medical mask, entered the same room as V6, with R2 and R3 present and unmasked, and began to perform housekeeping services. Upon exiting the room of R2 and R3, V8 noted (surveyor) in the hall and bent down behind the housekeeping cart to remove the medical mask and put on an N95 mask. At 1:25 pm, V8 confirmed V8 was in the room (XXX, room of R2 and R3). 3) On 6/22/22 at 11:50 am, V9 (Activity Aide) was in a standing position at a 36-inch-wide table in the activity room cutting paper designs. V9 was not wearing any type of mask at all. R7 and R8 were seated in wheelchairs directly on the opposite side of the table. R7 was unmasked and R8 had a mask that was pulled down below the chin onto the neck area. V9 upon seeing (surveyor) stated, I'm sorry, I just went to get a drink of water and forgot to put my mask back on. On 6/22/22 at 12:46 pm, V1 (Administrator) stated, We talk about the PPE requirements every morning in morning meetings and these requirements are drilled into their heads. V1 confirmed, The PPE requirement for all staff in the presence of a resident is to wear an N95. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) On 6/23/22 at 2:26 pm, V21 (Activity Aide) was seated at a 4-foot square table in the dining/ activity room at the end of the facility's XXX Hall, loudly calling out bingo numbers for a resident activity. V21 continuously had an N95 mask pulled down below the chin in the neck area. V21 stated, Well they (residents) can't hear me with the mask. V21 further stated, We don't have a microphone PA (Public Address) to use. R13 and R14 were seated at this same table with V21. R13 had a mask that was pulled down below the chin and R14 was unmasked. On 6/23/22 at 4:15 pm, V1 (Administrator) stated, We do have a karaoke machine with a microphone (V21) could use for bingo, but I guess (V21) didn't think of it. V1 also acknowledged the residents could have been seated at a different table if (V21) needed to have the mask lowered. V1 repeated the statement, We drill this PPE requirements into the staff's heads every day, and I mean every single day.