STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145825	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Elgin Rehab & Hcc	746 West Spring Street South Elgin, IL 60177

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 - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944 Based on observation, interview, and record review the facility failed to follow the State Department of Public Health and the Local County Health Department instructions to obtain appropriate facility-wide testing, initiate treatment for a resident (R1) with positive test results, and adhere to the mandated facility-wide masking for the management of their group A streptococcal disease outbreak. This applies to all the residents residing at the facility. Findings include: The facility's resident roaster dated 9/12/2024 showed a census of 56 residents. 1. The CDC (Center for Disease Control and Prevention) website link https://www.cdc.gov/group-a-strep/about/index.html dated 3/1/2024 documents, Group A Streptococcus (group A strep bacteria) can cause serious and deadly clusters or outbreaks. Group A strep bacteria are very contagious. Some people infected with group A strep bacteria don't have symptoms or seem sick. They can still spread the bacteria to others. Generally, people spread the bacteria to others through respiratory droplets or direct contact. The link continued to document, CDC developed these investigation tools to provide detailed approaches to investigating and controlling GAS (Group A Streptococcus) infections and outbreaks in LTCFs (Long Term Care Facilities) .Collaboration is key LTCF staff should work with their local public health departments when investigating suspected GAS outbreaks. On 9/12/2024 at 2:45 PM, V12 (Certified Nurse Assistant/CNA) said she had tested positive for Strep A during the facility's wide outbreak testing for Strep A on 8/1/2024. V12 said she was asymptomatic but received and completed her antibiotic treatment. V12 said she did not believe there was currently an active case of Strep A infection at the facility. (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 - Many	On 9/12/2024 at 3:40 PM, V1 (Administrator), V2 (Director of Nursing), and V3 (Assistant Director of Nursing/Infection Preventionist) said the facility had an active Strep A infection outbreak. They said they were all new to their roles at the facility. They said they were not sure when the outbreak started, how many cases there were, and which residents were associated with the facility's outbreak. They continued to say they were aware of the facility's mandated masking for all residents, staff, and visitors from the State Department of Public Health and the Local County Health Department. V1 said on 8/1/2024 the Local Health Department's lab went to the facility to perform the facility-wide testing on all the residents and staff. V1 said she was notified R1's right foot wound culture and V12's (Certified Nurse Assistant/CNA) throat culture resulted positive for Strep A. V1 continued to say that on 8/28/2024 the Local Health Department's lab went back to the facility to retested R1 and V12. V1 said on 9/11/2024 she was notified that R1's right foot wound culture continued to test positive for Strep A. On 9/13/2024 at 9:25 AM, V14 (IDPH Infection Control Coordinator) said he and the Local Health Department had initiated a retrospective investigation and had identified 5 resident iGAS Strep A infections at the facility. V14 said the State Department of Public Health and the Local County Health Department used the CDC's (Center for Disease Control and Prevention) guidelines for Group A Streptococcus Infections in Long-Term Care Facilities to assist the facility with their outbreak management including testing and infection control practices. V14 said the facility's prior management was notified of the facility's outbreak in May 2024 and routine onsite visitations were conducted at the facility to assist them with their outbreak. V14 said the facility's prior management had failed to obtain accurate employee assessment survey questionnaires and perform facility-wide testing for staff in June 2024 as instructed. V14 said the facility had also failed to obtain proper cultures for residents identified at risk in July 2024 as instructed. V14 said because the facility failed to assist the State Department of Public Health and the Local County Health Department with the facility's outbreak management and investigation they decided to mandate masking for all residents, staff, and visitors at the facility in July 2024. V14 said then the Local County Health Department assisted the facility with obtaining appropriate testing for staff and residents on 8/1/2024. V14 said that during the facility's wide-testing 2 additional cases were identified (R1 and V12). V14 said the facility was notified that their mandated masking had to continue till December 2024. V14 said he was concerned during his last onsite visit on 9/9/2024 because he observed several staff and residents without masks. On 9/13/2024 at 3:40 PM, V13 (Local County Health Department Communicable Disease Supervisor) said she notified the facility they had an iGAS Strep A outbreak in May 2024. V13 said she and V14 (State Department of Public Health Infection Control Coordinator) have been trying to guide the facility with their management of the outbreak. V14 said they have been providing the facility with guidance tools and conducting routine onsite visits to further assist them. V13 said they have continued to identify serious infection control concerns regarding the facility's lack of response to their recommendations with obtaining appropriate facility-wide testing and adherence to the facility-wide masking mandate. V14 said the facility is still in an outbreak. V14 said the facility's retrospective investigation is ongoing to further identify any additional iGAS Strep A infections associated with the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The document titled Local County Health Department Meeting Minutes dated 6/4/2024 showed the facility was instructed on infection control interventions based on the onsite visitation conducted by the State Department of Public Health and the Local County Health Department for management of their current outbreak of invasive group A streptococcal disease at the facility. The document said, [V14] explained that specimen collection sites must be decided based on the presence of symptoms or conditions; a standard throat swab cannot be utilized for all; [facility] team confirmed that new specimens will be collected from the residents accordingly, and cultures will be made. The document also said, [V13 and V14] reinforced the importance of staff responding the survey accurately to allow for identification of symptomatic individuals (for GAS or iGAS) and appropriate selection of specimen collection sites (i.e., if they have skin or nail wounds, specimen must be collected from those sites) .[V13] recommended that the facility tries to identify and test by culture all epi-linked staff (staff who provide direct care for the case with the last onset date); if this is not feasible, all staff must be cultured. The document continued to say the facility agreed the next steps would be taken, [Facility] will reassess residents and do additional testing as needed for individuals with wounds or ostomy sites. [Facility] will complete reassessment for GAS. [Facility] will identify and test epi-linked staff regardless of symptoms; if unable to identify epi-linked staff, all staff members will be tested (and treated accordingly). The document titled Local County Health Department Meeting Minutes dated 7/10/2024 said, the staff assessment and reassessment had not been completed by the facility. The document continued to document that the facility was again educated and provided basic containment guidance for the management of their Strep A iGAS outbreak. The document titled Local County Health Department Meeting Minutes dated 7/15/2024 showed the facility was notified that a total of 5 cases had been identified as part of the facility's retrospective investiation outbreak and it was highly suspected that disease transmission was ongoing at the facility. The document said, [Physician] (Regional Infection Prevention Program-[NAME]) pointed out to the fact that, since only 2 of the 5 cases in the outbreak had wounds, droplet must be considered as the main mode of transmission; considering that culture screenings from residents were negative, and that no staff has been tested yet, adoption of broad masking is a simple containment measure and should be implemented during the outbreak. The document continued to say the recommended next steps would be taken, Recommended implementing universal masking at [facility]. Recommend testing by culture all facility employees, including contractors, EVS, and non-clinical employees; throat swab is the recommended specimen collection method. Contact (laboratory) to discuss screening of staff at the occasion of specimen collection. If any wounds are identified, (Laboratory) to collect specimens from wounds as well. The facility's document titled Resident Infection Control and Antimicrobial Log dated August 2024 showed on 8/1/2024 lab wound specimen cultures were obtained from R1-R6 and R11-R13. The report said R1 tested positive for Strep A and R1-R3, R5, R6, and R11-R13 also tested positive for MRSA (Methicillin-resistant Staphylococcus aureus). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The CDC's (Center for Disease Control and Prevention) document titled Decision Tool for Investigating Group A Streptococcus Infections in Long-Term Care Facilities dated 3/1/2024 said LTC (long-term care) facilities should identify additional symptomatic cases, identify potential asymptomatic carriers, assess infection control measures, and conduct an epidemiologic and laboratory investigation when they have an iGAS outbreak. The document said, Footnotes a. If GAS is isolated from a wound AND accompanied by necrotizing fasciitis or streptococcal toxic shock syndrome, then it is considered an invasive GAS infection case .b. Often cases of invasive GAS will first be identified either by an acute care hospital where the resident of an LTCF has been transferred for additional evaluation and medical care or by a laboratory that processes specimens collected at LTCFs. Thus, these facilities should ensure that invasive GAS infection or positive GAS cultures collected from normally sterile body sites are reported to local public health authorities and the LTCF where the patient resides. Additionally, these facilities should save the isolate for possible future assessments of strain relatedness in case additional cases are identified .Note: Continued use of a facemask by HCP during all wound care activities or when handling invasive medical devices is recommended until the outbreak is over . The facility's policy titled Infection Control Surveillance and Monitoring with a revised date of 4/11/2022 said Policy: It is the policy of the facility to do routine surveillance and monitoring of the facility to determine if compliance with infection control practices is maintained .Procedure: 1. Monitoring the effectiveness of the facility work practices and protective equipment will be conducted by the Administrator, ICP, and DON. This includes but is not necessarily limited to: a. Surveillance of the facility to ensure that required work practices are observed and protective clothing and equipment are provided and properly used; b. Investigation of known or suspected parenteral exposure .c. Improvement in training, work practices, or protective equipment to prevent recurrence. d. Maintain a procedure of notification to physicians, and (State Department of Public Health) as required by regulation, of any infectious cases. e. Review all policies, procedures, and programs relating to infection control including environmental controls . 2. R1's Medical Record showed an admitted [DATE] with diagnoses of necrotizing fasciitis to his right foot wound, non-pressure chronic ulcer of the right heel and midfoot with fat layer exposed, and soft tissue disorders. On 9/12/2024 at 10:15 AM, V3 (Assistant Director Nursing/ADON) said she was the facility's IP (Infection Preventionist). At 10:30 AM during the facility's infection control observation round done with V3, R1's room had an EBP (Enhanced Barrier Precaution) sign tapped outside his room. V3 said that was incorrect because R1 was supposed to be under Contact Precautions because of his Strep A wound infection to his right foot wound. V3 said R1 had tested positive for Strep A to his right foot wound on 8/1/2024 during the facility's Strep A outbreak testing. V3 said R1 was placed on contact precautions and started on an oral antibiotic on 8/9/2024. V3 said R1's wound was retested for Strep A on 8/28/2024 as part of the facility's outbreak management. V3 said the facility was notified on 9/11/2024 that R1 had again tested positive for Strep A. V3 said she notified R1's physician and received an order for an oral antibiotic and to continue with contract precautions. V3 continued to say R1 frequently went out on pass overnight and he was currently out on pass. V3 said R1 went out on pass on 9/11/2024 and was not expected back for 8 days. V3 said she had called R1 and notified him of his test results and the antibiotic order. V3 said she was waiting to hear back from R1 to call in his antibiotic prescription to a local pharmacy. On 9/13/2024 at 10:30 AM, V3 said she still had not made contact with R1 and was planning to call him later that day. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/12/2024 at 2:45 PM, V12 (Certified Nurse Assistant/CNA) said she was familiar with R1 and had taken care of him. V12 said she had tested positive for Strep A during the facility's wide outbreak testing for Strep A on 8/1/2024. V12 said she had been asymptomatic but received and completed her antibiotic treatment. V12 said she did not believe there was currently an active case of Strep A infection at the facility. V12 said she believed R1's wound infection was not Strep A. V12 said she uses the precaution signs outside residents' rooms to instruct her what type of precautions and PPE (Personal Protective Equipment) she needed to use when entering the rooms to protect herself and others. On 9/13/2024 at 11:30 PM, V1 (Administrator) said R1 frequently went out on pass overnight. V1 said R1 was frequently non-compliant with his right foot's wound care. V1 said R1 had not started his oral antibiotic treatment ordered on 9/11/2024 for his known Strep A wound infection. V1 said she was unable to locate a facility's out-of-pass policy. R1's Wound Evaluation and Management Summary dated 9/4/2024 said R1 had a full-thickness post-surgical wound to his right dorsal foot. The summary said the wound measured 8.1 x 4.0 x 0.1 cm (centimeters) and had heavy serosanguinous exudate. The summary continued to say that R1 now required daily dressings. R1's physician orders dated 9/11/2024 said start Amoxicillin (antibiotic) 500 mg PO TID x 10 days for Strep group A on foot wound and continue contact isolation for Strep group A on wound. R1's progress note dated 9/11/2024 said R1 was to start Amoxicillin 500mg PO TID x 10 days to start when resident comes back from out on pass for 8 days, resident was called and notified. R1's progress note dated 9/3/2024 said R1 complained of his right foot wound dressing being saturated through his sock. The progress noted said when the dressing was removed it was noted with abnormal smelling and large amount of drainage. The progress note said R1's nurse practitioner was notified and an order for daily dressing changes was obtained. R1's right foot wound culture dated 8/04/2024 showed R1 had a positive culture for Moderate Growth Beta Hemolytic Strep Group A (Abnormal). R1's care plan dated 9/12/2024 showed R1 had a beta hemolytic strep group A infection on his foot initiated on 8/15/2024. The care plan had multiple interventions including Educate resident/family/staff regarding preventive measures to contain the infection and Place in private room with contact isolation precautions initiated on 8/15/2024. R1's care plan also showed that R1 had a behavior problem related to not following the facility's policies regarding the out-on pass initiated on 3/19/2024. R1's care plan said, Resident has a wound on his right lower leg that needs attention, daily dressing change is important which is not done when he is not in the facility overnight. The care plan had multiple interventions including Explain all procedures to the resident before starting .If reasonable, discuss resident's behavior. Explain/reinforce why behavior is inappropriate and /or unacceptable to the resident initiated on 3/19/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The CDC's (Center for Disease Control and Prevention) document titled Decision Tool for Investigating Group A Streptococcus Infections in Long-Term Care Facilities dated 3/1/2024 said, Additional PPE use, as described below, is recommended to control a GAS outbreak. Residents with suspected or confirmed GAS infection from a wound, ostomy, or device-insertion site should remain on Contact and Droplet Precautions until 24 hours after the initiation of effective antibiotic therapy and any wound drainage stops or can be contained by a dressing. HCP should then return to use of EBP (Enhanced Barrier Precautions). 3. On 9/12/2024 at 8:230 AM, R6 and R7 were unmasked in the facility's common areas. R6 was sitting in the hallway leading to the open dining room area and R7 was sitting in the open dining room area. At this time other residents were being transported in and out of the dining room. At 9:05 AM V9 (Activity Aide) was unmasked while walking across the dining room where there were residents in the area. At 1:40 PM V9 was talking to R7 in the dining room where there were other residents. V9's surgical mask was placed underneath her nose and R7 was unmasked. At 1:43 PM V9 said she was unmasked in the morning because she entered the facility from the back-side entrance where there were no surgical masks available. V9 continued to say she was required to wear a surgical mask to cover her nose and mouth to protect herself and others. On 9/12/2024 at 3:40 PM, V3 (Assistant Director of Nursing/ADON) said all facility staff, residents, and visitors had to be masked because of the facility's Strep A outbreak. V3 said failure to adhere to the mandated facility-wide masking can result in the spread of the disease. The facility's policy titled Face Mask/Face Shield/Goggles dated 12/2009 showed Policy: Varies types of protective apparel are worn to prevent contamination and the possibility of splattering of blood or body fluids. Protective equipment is to be worn according to the Center for Disease Control Guidelines .A surgical mask is generally worn to provide protection against spread of infectious large-particle droplets that are transmitted by close contact .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944 Based on observation, interview, and record review the facility failed to safely repair an exposed ceiling area located outside residents' (R8, R9, and R10) rooms. This applies to 3 of 8 residents reviewed for environmental hazards. The findings include: On 9/12/2024 at 8:32 AM, during the facility's environmental rounds, there was an open ceiling area with exposed pipes above the entrance of the housekeeping room. The housekeeping room was in the the resident hall in front of R8, R9, and R10's rooms. The cut-out open ceiling area had a loose plastic covering with a moderate amount of drywall debris. The plastic covering was not properly secured it had scattered pieces of blue painter's tape. At 11:45 AM, V4 (Housekeeper Supervisor) said approximately three weeks ago there had been a pipe leak above the housekeeping room entrance area. V4 said the facility did not have maintenance staff available to fix the open ceiling drywall area. V4 said the open ceiling area had remained with the same plastic covering and tape. V4 said the facility's corporate management was planning to send someone to patch up the ceiling but was unsure when. On 9/12/2024 at 12:05 PM, V1 (Administrator) said approximately a month ago the nursing staff informed her there was a ceiling leak outside the housekeeping room. V1 said an outside plumbing company fixed the leak but the ceiling area remained open with exposed pipes. V1 said the opening measured approximately 3 x 3 ft (feet). V1 said the facility did not have maintenance staff to repair the ceiling. V1 said she requested the corporate management to send someone to patch up the ceiling but was unsure when it would be repaired. The facility's resident roster report dated 9/12/2024 showed R8's room and R9 and R10's room were located directly across from the housekeeping room. The facility's undated document titled Maintenance Minute showed The Maintenance Minute is a one to two page quick update on maintenance [NAME], some tips for routine maintenance and refreshers for Life Safety .maintenance Training Quick Guide .Repair any wall or ceiling damage as soon as possible to maintain smoke barrier.