STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146028	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Estates of Lincolnshire	150 Jamestown Lane Lincolnshire, IL 60069

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** 35541 Based on observation, interview and record review the facility failed to follow their contact isolation policy by failing to implement contact isolation precautions for a resident (R3) with a suspected contagious skin rash. The facility failed to ensure a resident (R3) diagnosed with scabies remained isolated from other residents. The facility failed to disinfect and sanitize a communal shower room after a resident (R3) diagnosed with scabies was showered in the room, failed to handle the personal belongings of a resident (R3) diagnosed with scabies, in a manner to prevent cross contamination to others (R7) and failed to ensure housekeeping staff wore the required personal protective equipment (PPE) when cleaning the room of a resident (R6) on contact isolation for a rash. These failures have the potential to affect all 95 residents in the facility. Findings include: The Facility Data Sheet dated 9/25/24 showed a resident census of 95. A facility's Skin Check/Line list printed on 9/25/24 showed an outbreak of scabies was identified in the facility on 9/21/24 after three residents (R3, R7, R8) developed rashes and were treated for scabies. The list showed, as of 9/25/24, a total of eight residents in the facility had rashes and were being treated for scabies. R3 was the first resident to be treated for scabies. 1. R3's progress note dated 9/9/24 showed R3 had new areas of red itching rashes to both of his arms. R3 refused treatment for the rash. R3's progress notes date 9/10/24 showed R3 had rashes visible to residents arms and back. R3 was observed with R7 in a common area of the facility. R3 continued to refuse to be treated for his rashes. R3's progress note dated 9/18/24 showed R3 left the facility to go to a doctor's appointment. The note showed R3 returned to the facility with a prescription for Permethrin External Creme 5% (medication to treat scabies) to apply to his rashes as directed. A physician order for R3 dated 9/18/24 showed R3 was placed on contact isolation due to an active infection (suspicious rashes). Isolation precautions were not implemented on R3 until nine days after facility staff initially noted R3's rashes. (continued on next page)

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	A Medical Professional Progress note, for R3 dated 9/23/24, showed, Patient is a [AGE] year old male being followed for scabies . rash noted to BUE (bilateral upper extremities), chest, abdomen, flank areas-consistent with scabies. Patient to have second Permetherin (creme to treat scabies) 9/25/24. Patient with extensive rash, will treat with Ivermectin (oral medication to treat scabies) 9/23/24 and 9/30/24 .Patient noted to be scratching several times during conversation . Isolation per facility protocol . A physician order dated 9/23/24 showed R3 was to remain on contact isolation due to continued rashes and active infection, scabies. Resident remains in the room at all times. All services to be rendered inside the room, every shift. On 9/25/24 at 9:35 AM, a Contact Isolation sign hung on the door to R3's room. R3 exited his room via his electric wheelchair as V7 Certified Nursing Assistant (CNA) walked next to him. V7 CNA escorted R3 into a communal shower room, located on one of the units of the facility, and shut the door. At 10:05 AM, R3 remained in the room with V7 CNA as she assisted R3 with showering. At 10:12 AM, R3 was back in his room, seated in his wheelchair. V7 CNA exited the shower room. When V7 was asked if the shower room had been cleaned since R3's shower, V7 stated she just sprayed the shower with this shower spray. From 10:12 AM-10:38 AM, a continuous observation was made of the shower room. No staff arrived to clean the shower room. At 10:38 AM, this surveyor asked V6 Registered Nurse (RN) if there was any housekeeping staff on the unit, V6 stated, No not right now. I don't know who is supposed to be. From 10:40 AM-10:52 AM, a continuous observation was made of the shower room. No housekeeping staff arrived to clean the room. At 10:53 AM, V7 CNA entered the potentially contaminated shower room, without donning any PPE, and shut the door. At 12:05 PM, V9 Housekeeper was on the unit, cleaning resident rooms. When V9 was asked if she had cleaned the communal shower room yet, V9 stated, No, I have all of the other rooms to do yet. I will try to get to it. No one told me it needed to be cleaned. On 9/25/24 at 12:02 PM, R3 was in his electric wheelchair, out of his room, by the nurses station on his unit talking to V5 CNA. R3 had a black and blue cloth bag in his hand. R3 saw this surveyor, said something to V5 CNA, dropped the bag on the floor by the nurses station, and wheeled himself into his room. V5 CNA then picked up the cloth bag, with a glove hand, walked the bag down to R7's room, and handed the bag directly to R7. On 9/25/24 at 11:20 AM, V3 Assistant Director of Nursing (ADON)/Infection Preventionist (IP) stated, (R3) is still on isolation because he is still has rashes and is itching. He should be in his room. All cares should be done in his room. If he uses the shower room on the unit, staff are to call housekeeping to get the room clean immediately after he's done showering. Staff and residents should stay out of the shower room until it's clean. The should place a sign on the shower door to keep out until it's clean. V3 stated any personal belongings of R3 should remain in R3's room. V3 stated, Staff should have intervened if (R3) tried to give a bag or personal belongings to another resident. He could be potentially re-infecting or infecting someone by doing so. V3 stated R3 should have been put on isolation as soon as staff noticed the his rashes wether R3 refused treatment for the rashes or not. On 9/25/24 at 1:07 PM, V10 Director of Housekeeping stated staff are to notify housekeeping immediately when a shower room needs to be cleaned after a resident with scabies had used the room. V10 stated, We have to bleach and disinfect the entire room before anyone can use the room again. (continued on next page)

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