STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145806	A. BUILDING _____ B. WING _____	04/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WARREN PARK HEALTH & LIVING CTR	6700 NORTH DAMEN AVENUE CHICAGO, IL 60645

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent the spread of infections such as COVID-19 as evidenced by failure to adhere to infection control practices related to: staff failure to disinfect high-touch surfaces; staff failure to promptly dispose of single-use supplies; staff failure to observe isolation precautions including proper use of personal protective equipment (PPE); staff failure to remind two residents (R1,R5) to properly use a face mask; and staff failure to perform hand hygiene and utilize gloves properly. Findings include: 1. A. On 4/8/20 at 11:02am, a used tissue wipe was observed on top of the isolation cart outside of room [ROOM NUMBER]. Licensed Practical Nurse1 (LPN1) confirmed and disposed of the tissue in the trash bin. LPN1 performed hand hygiene. LPN1 did not disinfect the top of the isolation cart. When asked, LPN1 stated that sometimes residents would leave items on top of carts. LPN1 added, It should be disinfected. B. On 4/8/20 at 11:13am, Registered Nurse1 (RN1) was observed bringing supplies on a tray to R2's room to check his blood sugar. RN1 placed the tray on R2's bedside table. RN1 returned to the nurses' station and placed the tray on top of the medication cart. RN1 performed hand hygiene. RN1 disinfected the glucometer and disposed of the tray in the trash bin. RN1 performed hand hygiene. RN1 did not disinfect the top of the medication cart. This was confirmed by LPN1. When RN1 was asked if the tray should be placed on top of the cart after use inside a resident's room, RN1 stated, Ideally not. RN1 further stated, I will disinfect it. During interview with the Director of Nursing (DON) on 4/8/20 at 3:50pm, when asked about her expectation from staff on single-use items brought into the resident's room, the DON stated, It should have been discarded right away. During a follow-up interview with the DON on 4/9/20 at 1:09pm, when asked what staff would use to disinfect surfaces like isolation carts and medication carts, the DON stated, We have a different cleaning agent used to clean the isolation carts and med carts. Housekeeping uses it but is also accessible to nurses. CNAs can ask the nurse if needed. Further interview revealed that the facility used Clorox Disinfecting wipes for the high-touch surfaces. When asked if staff should disinfect the medication cart if an item used in the resident's room was placed on top of the cart, the DON stated, Yes. Review of the undated facility policy titled Cleaning and Disinfection of Resident-Care Items and Equipment revealed, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard .c. Non critical items are those that come in contact with intact skin but not mucous membranes .(2) Most non-critical reusable items can be decontaminated .6. Intermediate and low-level disinfectants for non-critical items include: a. Ethyl or [MEDICATION NAME] alcohol, b. Sodium hypochlorite, c. [MEDICATION NAME] germicidal detergents, d. [MEDICATION NAME] germicidal detergents; and e. Quaternary ammonium germicidal detergents. In a CDC article titled Preparing for COVID-19: Long-term Care Facilities, Nursing Homes with review date of 3/21/20 revealed under Environmental cleaning and disinfection revealed, A new respiratory disease - coronavirus disease 2019 (COVID-19) - is spreading globally and there have been instances of COVID-19 community spread in the United States. The general strategies CDC recommends to prevent the spread of COVID-19 in LTCF are the same strategies these facilities use every day to detect and prevent the spread of other respiratory viruses like influenza .Make sure that EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html 2. A. On 4/8/20 at 11:07am, R1 was observed walking on the first floor. R1 was wearing a face mask but R1's nose was exposed. Although staff were present in the hall, no one reminded R1 to wear the mask properly. B. On 4/8/20 at 11:34am, R5 was observed standing in front of the third floor nurses' desk next to R1. Both R1 and R5 were wearing their masks but noses were exposed. R1 and R5 were talking to the Social Service Staff (E2) and Housekeeping Staff (E3). E2 and E3 did not remind R1 and R5 to wear their masks properly. R1 and R5 were observed walking down the hallway still wearing their masks but noses were exposed. C. On 4/8/20 at 11:44am, Dietary Staff4 (E4) was observed on the first floor, delivering the cart of lunch trays, wearing a mask but E4's nose was exposed. D. On 4/8/20 at 12:09pm, Dietary Staff4 and Dietary Staff5 (E4 and E5) were observed wearing their face masks inside the kitchen but their noses were exposed. E5 walked to the sink. E5 was observed standing too close approximately a foot away from the unnamed dietary staff who was still washing his hands. This was confirmed by the Dietary Manager (DM). When DM was asked if staff are allowed to wear their masks with their nose exposed and should keep their distance, the DM looked at her staff and reminded E4 and E5 to wear their mask properly and reminded all Dietary Staff to follow social distancing guidelines of six feet. During interview with the Director of Nursing (DON) on 4/9/20 at 1:09pm, when asked if residents were encouraged to wear a mask, the DON stated, Offered. Recommended. We also provide tissue. When asked if she expected staff to remind residents on how to use the masks properly, the DON stated, Yes. Correct. The DON further added that they implemented universal mask use for all staff and added, Wear it appropriately like all staff do. Review of undated facility policy titled Personal Protective Equipment - Using Face Mask, revealed under Miscellaneous, #2 Be sure the face mask covers the nose and mouth while performing treatment or services for the patient. Under Procedure Guidelines Putting on the Mask revealed, #5 Place the mask over the nose and mouth . In a CDC article titled Recommendation Regarding the Use of Cloth Face Coverings, Especially in Areas of Significant Community-Based Transmission with review date of 4/3/20 revealed, CDC continues to study the spread and effects of the novel coronavirus across the United States. We now know from recent studies that a significant portion of individuals with coronavirus lack symptoms (asymptomatic) and that even those who eventually develop symptoms (pre-symptomatic) can transmit [MEDICAL CONDITION] to others before showing symptoms. This means that [MEDICAL CONDITION] can spread between people interacting in close proximity-for example, speaking, coughing, or sneezing-even if those people are not exhibiting symptoms. In light of this new evidence, CDC recommends wearing cloth face coverings in public settings where other social distancing measures are difficult to maintain . It is critical to emphasize that maintaining 6-feet social distancing remains important to slowing the spread of [MEDICAL CONDITION]. CDC is additionally advising the use of simple cloth face coverings to slow the spread of [MEDICAL CONDITION] and help people who may have [MEDICAL CONDITION] and do not know it from transmitting it to others. https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover.html 3. A. On 4/8/20 at 11:22am, R3 was observed inside his room. During record review, R3 was on contact precautions for eye infection. R3 had an order on 4/7/20 for [MEDICATION NAME] B TMP (antibiotic) eye drops 1 drop to both eyes twice a day for seven days. R3 was started on this medication on 4/7/20 at 6pm. R3 received two doses of the medication. The Business Office Manager (BOM) was observed distributing funds to residents with the help of Activity Staff1 (E1). The BOM had a cart carrying the funds, a white paper, pens, a notebook and a bottle of sanitizer. Wearing a mask, E1 went into R3's room. E1 did not wear gloves. E1 came out of R3's room. E1 did not perform hand hygiene. E1 brought a paper and pen into R3's room and gave R3 some money. This was confirmed by the BOM. E1 came out of R3's room. E1 did not perform hand hygiene and did not disinfect the supplies. E1 touched the basket on the bottom of the cart containing packs of cigarettes. E1 placed the basket on the floor for several seconds and returned the basket to the bottom of the cart without disinfecting the bottom of the basket. R3 and R4 shared a

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

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) room. E1 did not perform hand hygiene before going back into the room. E1 brought the paper and pen to R4. E1 came out of R4's room and placed the paper and pen on top of the cart. E1 did not disinfect the supplies and did not perform hand hygiene. E1 gave R4 some cash. E1 came out of R4's room. E1 did not perform hand hygiene. When asked, E1 was unsure if he needed to perform hand hygiene. LPN1 was present during this observation. B. On 4/8/20 at 11:37am, Housekeeping Staff3 (E3) was observed putting on gloves and went to room [ROOM NUMBER] with two rolls of toilet paper. E3 came out of the room with gloves on. E3 went to the nurses' desk, removed his right glove and picked up the phone with the left hand while still wearing the left glove. E3 did not perform hand hygiene after removing his gloves. This was confirmed by LPN1. When E3 was asked what he missed to do, E3 stated, I should wash my hand before leaving the room. I will get some sanitizer for the phone. C. On 4/8/20 at 11:47am, Certified Nursing Assistant1 (CNA1) washed her hands before passing the lunch trays. CNA1 took the first lunch tray from the cart and went to room [ROOM NUMBER]. CNA1 came out of the room. CNA1 did not perform hand hygiene. CNA1 took the coffeepot and brought it inside room [ROOM NUMBER] and returned it on the cart parked by the hallway. CNA1 did not perform hand hygiene. CNA1 took the second tray and brought it inside room [ROOM NUMBER]. CNA1 came out and grabbed some sugar from the basket on the bottom of the cart and went back to room [ROOM NUMBER]. CNA1 came out of room [ROOM NUMBER]. CNA1 did not perform hand hygiene. CNA grabbed another lunch tray and went into room [ROOM NUMBER]. When CNA1 came out and was asked, CNA1 was unsure of the need to perform hand hygiene when passing out lunch trays inside the rooms. CNA1 was reminded by the surveyor to perform hand hygiene after leaving a resident's room or after coming in contact with a resident. D. On 4/8/20 at 11:54am, CNA2 was observed going into room [ROOM NUMBER]. CNA2's hand touched the curtain inside the room. CNA2 came out of the room. CNA2 did not perform hand hygiene. CNA2 continued to pass the lunch tray to the next room. CNA2 did not perform hand hygiene. This was confirmed by LPN1. When asked, CNA2 stated she did not have a hand sanitizer in her pocket. CNA2 also stated she did not know she had to sanitize her hands. E. On 4/8/20 at 11:56am, CNA3 was observed bringing the coffee pot and the water pitcher inside room [ROOM NUMBER]. CNA3 came out of room [ROOM NUMBER] with the water pitcher and the coffee pot. CNA3 did not perform hand hygiene. F. On 4/8/20 at 11:58am, R6 was observed by his bedroom door and handed CNA2 his finished lunch tray. CNA2 placed R6's tray in the same cart where there were four more uneaten lunch trays that needed to be served. The open food cart did not have a divider in the middle to separate the soiled lunch trays and the clean lunch trays. CNA2 placed R6's finished lunch tray across from the clean lunch trays that needed to be served. CNA2 did not perform hand hygiene. CNA2 continued to pass out the remaining lunch trays. During interview with the Director of Nursing (DON) on 4/8/20 at 3:50pm, when asked about her expectation from staff on hand hygiene and disinfection of items, the DON stated, Yes, they need to sanitize. When further asked about her expectation from staff to perform hand hygiene after removal of gloves, the DON stated, After glove use. Yes. During a follow-up interview with the DON on 4/9/20 at 1:09pm, when asked about her expectation from staff who entered an isolation room, the DON stated, That they (staff) would follow the precautions for the reason they (residents) are isolated. When asked what staff should do after care in the isolation room and for the items used, the DON stated, Appropriate disposal of PPE and proper hand hygiene. Sanitize any equipment that was taken into the room. They (equipment) should be cleaned before and after use on a resident. When asked about passing of lunch trays, coffee and water, the DON stated, They (staff) should distribute the lunch trays first before picking up the trays of the residents who were done eating. They should be filling the cups at the cart and not bring them (coffee pot and water pitcher) into residents rooms. Review of undated facility policy on Handwashing/Hand Hygiene revealed, This facility considers hand hygiene the primary means to prevent the spread of infections .#7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents .i. after contact with a resident's intact skin .n. Before and after entering isolation precaution settings . Review of undated facility policy titled Coffee/Fluid Carts revealed under procedure, Employees will utilize fluid carts to prepare fluids to residents .Employees will prepare fluids per resident at cart and take to resident. Review of undated facility policy titled Isolation-Categories of Transmission-Based Precautions revealed under Contact Precautions, 1. Contact Precaution may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment .4. Staff and visitors will wear gloves (clean, non-sterile) when entering the room .b. Gloves will be removed and hand hygiene performed before leaving the room. In a CDC article titled How COVID-19 Spreads with review date of 4/2/20 revealed, It may be possible that a person can get COVID-19 by touching a surface or object that has [MEDICAL CONDITION] on it and then touching their own mouth, nose, or possibly their eyes. This is not thought to be the main way [MEDICAL CONDITION] spreads, but we are still learning more about this virus. CDC recommends people practice frequent hand hygiene, which is either washing hands with soap or water or using an alcohol-based hand rub. CDC also recommends routine cleaning of frequently touched surfaces. https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html