STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145648	A. BUILDING _____ B. WING _____	07/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CENTRAL NURSING HOME	2450 NORTH CENTRAL AVENUE CHICAGO, IL 60639

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** Based on observation, interview and record review, the facility staff failed to designate the COVID-19 Rooms, failed to ensure staff properly donn (put on) and doff (remove) PPE (personal protected equipment) when exiting COVID-19 isolation rooms, failed to sanitize hands when leaving COVID-19 room, failed to use disinfectant/sanitizer per manufacturer's guidelines, failed to handle isolation/COVID-19 laundry to prevent the spread of COVID-19, failed to ensure the dish machine was sanitizing and failed to have infection control/housekeeping policies detailed toward their facility. These failures were on 1 of 1 nursing units affecting all 45 residents residing on the first floor including the 4 (R1, R2, R3, R4) of 4 sampled residents reviewed for infection control in the sample of 4 residents. The findings include: On 7/7/20 at 9:40 AM, in the main kitchen with V1 (administrator) and V9 (Food Service Supervisor), V8 (Dishwasher/Dietary Aide) stated the dish-machine is a high temperature one. V8 stated the gages on the dish-machine are used and recorded on a log. The log was presented and there was one temperature recorded 180 degrees Fahrenheit (F.) for all entries under the wash section. The final rinse temperature section had times and staff initials. The form was not filled out correctly in which V8 agreed. As the dish machine ran, the wash gage did not move and the final rinse gage was moving up to 180 degrees F. V8 stated the staff record the gage temperature in log when asked about check and balance in place for testing accuracy of machine temps. Asked if Thermo-labels used, V8 stated she has some but does not usually use them. The Thermo-label test strip is to turn black when temperature reaches 160 degrees F. to ensure dishes are sanitized. V8 stated that the booster just kicked in. The wash gage was now moving up to 138 degrees F. V8 and V1 confirmed there is no work order for dish machine. The test strip never indicated dishes were sanitized. The thermolabel test strip was sent through 2 times and it did not change color. The facility's policy labeled Mechanical Cleaning and Sanitizing documents under High Temperature Dishwashers to ensure the water temperature no less than that specified by manufacturer which may vary from 150 degree F to 165 degree F. depending on the type of machine and the final temperature rinse temperature no less than 180 degrees F. This policy is not adapted to the facility. The policy should address the type of dishwasher and the required temperatures for wash and final rinse. The policy does not address the use of Thermo-label to check the sanitizing of dishwasher. On 7/7/20 at 10:10 AM, V5 (housekeeper) stated he is assigned to the 1st floor and has been employed for 5 years in facility. V5 was standing next to his housekeeper's cart and was asked how often the cart is cleaned. V5 stated at the end of everyday. The base of the cart had heavy accumulation of dirt, debris, black substances, white flour-like substance. V5 stated that he cleans the COVID isolation rooms at the beginning of the shift. V5 stated the 32 ounce spray bottle labeled in black marker bleach is filled half way of bleach and the other half is water. V5 stated that his eyes will water because the bleach is so strong he will add more water to dilute. V5 stated the bleach is used on the floors. The product labeled Strike Force is a quaternary ammonia in which V5 could not identify. V5 stated he will spray the surface, such as cabinet tops with the product, leave it on for 5 minutes and wipe off. The All Purpose Cleaner is used on the hand rails and door knobs. None of these products were found on the EPA (Environmental Protection Agency) N-list. The directions on the back of the STRIKE FORCE documents it is a quaternary ammonia and has a contact time of 10 minutes for the product to kill the pathogens but does not address the COVD-19 pathogen. The Purotab which is the All Purpose Cleaner does not have any contact times for the COVID-19. R3 is an oriented, [AGE] year old male who was admitted to the facility on [DATE] with no discharges per MDS (minimum data set) and nurses' notes. Per the 5/15/20 MDS, R3's BIMS (brief interview mental score) is 12 and requires extensive assistance with his activities of daily living (ADLs) and uses a wheelchair for mobility. On 7/7/20 at 10 AM, R3 is in his room resting along with R2 and R4. The sign on door reads Please see nurse. There was no signage on the type of isolation. There was one sign at entrance to the 1st floor nursing unit from the front lobby and another sign at the 1st floor elevator doors, both signs read, droplet precautions used in facility. V1 (Administrator) stated the whole facility is on droplet precautions and the COVID isolation rooms are 118 and 119. During the tour of 1st floor, there were other rooms with sign Please see Nurse on door of the isolation. Per V2 (Director of Nursing) and the facility's infection surveillance log, there is contact isolation for ESBL (Extended Spectrum Beta-Lactamase) of urine [MEDICAL CONDITION] ([MEDICAL CONDITION] Resistant Staphloccus Aureus) of wound which was all acquired within facility. At 11:45 AM, V12 (certified nurse aide) came out of COVID-19 isolation room for R2, R3 and R4 holding 2 dietary soiled trays with her bare hands. V12 took the dirty isolation food trays down hall to a food cart about 50 feet and placed dirty trays on the cart. As V12 walked toward the nurses' station, V12 was pulling off her disposable gown. V12 looks for somewhere to discard the gown and walks around the nurses' station and goes to an isolation cabinet near the nurses' station and finds a red bag and discards gown in red bag. Then takes red bag to the Soiled Linen Chute Room touching door knob, opens the chute door and tosses bag into chute. V12 then came back to the nurses' station to wash her hands. At this point, V12 has touched many surfaces and doorknobs without handwashing. V12 washes her hands then proceeds to go down another resident corridor as she removes the outer surgical mask and looks for a place to discard it. V12 went into another resident room and discarded the mask. V12 failed to follow facility's policy for handling infectious material by failure to double bag and failure to walk the isolation bag down to laundry. Earlier in day at 9:40 AM, V6 (laundry staff) stated the isolation linen is to be double bagged and carried down by hand to laundry. Throughout the first floor, all staff were dressed in double face masks/face shields, disposable gowns and gloves going from room to room, from isolation to non-isolation. R3 tested positive for COVID-19 on 5/3/20 per laboratory results which was resolved 5/27/20 per the care plan. There is a physician order [REDACTED]. R3 was asymptomatic during the timeframe and no test done to confirm the COVID-19 was not detected any longer. R3 was removed from isolation after 22 days. R3 tested positive for COVID-19 again on 7/4/20 per laboratory results. R3 was positive for COVID between 5/3/20 to 5/27/20 when he resided in 3 rooms 116 d, 101 b and 118 d. Neither of these rooms were designated as COVID rooms during this time frame per the list provided by the facility. Per the facility's list of COVID ROOMS and TRANSITIONAL ROOMS, R3 was in room [ROOM NUMBER] d between 5/3/20 to 5/4/20 when positive for COVID. In room [ROOM NUMBER] b between 5/4/20 to 5/16/20 and this room discontinued being COVID isolation on 5/8/20. In room [ROOM NUMBER] d between 5/16/20 to 5/27/20 when positive for COVID, in room [ROOM NUMBER] a between 5/27/20 to 7/3/20. These rooms were not designated as COVID-19 at these times. R4 is a an oriented, ambulatory [AGE] year old male who was admitted to the facility on [DATE] with no discharges per MDS and Nurses notes. Per R4's quarterly MDS 5/26/20 documents a BIMS 15, and requires supervision and limited assist for ADLs. R4's Care Plan (12/5/19) documents ineffective airway secondary to cough since 4/10/19 and up to 12/5/19 and Positive for COVID-19 as of 7/4/20. Per the Census sheet, R4 was on the 4th floor from 1/11/18 to 7/5/20 when he was moved to room [ROOM NUMBER] c on 7/5/20. Nurses notes 7/4/20 document R4 put into room [ROOM NUMBER] for COVID-19. R4 was on 4th floor when tested for COVID-19 on 6/30/20. COVID test results were available on 7/4/20 and R4 had critical levels detected. R4 on 4th floor for 5 days with positive COVID. On 7/7/20 at 11:45 AM with V2 (D.O.N.) and V3 (ADON), the facility's surveillance infection log (May 27, 2020 to July 7, 2020) was reviewed and neither was able to explain how the log is being utilized. The log is very difficult to follow and has no conclusions. The data for R3 is the same from month to month. Specimen collected 4/30/20 when R3 was in room [ROOM NUMBER]-b, date of on-set of symptoms are

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** - Many	(continued... from page 1) 4/23/20 but R3 is marked asymptomatic and placed on droplet precautions 4/12/20. R3 moved to room [ROOM NUMBER]-a but does not indicate when this happened There is nothing else documented on R3 such as discontinuing R3 isolation and the testing done on 6/30/20 and found positive on 7/4/20. V2 presented more papers with the 42 residents being diagnosed with [REDACTED]. Although, V11 (Registered Nurse) is the facility's Infection Preventionist, V2 and V3 stated they would go over the surveillance log. The facility presented a policy without their letter head and taken from a manual. The policy is not detailed to their facility. The nine page policy labeled INFECTION PREVENTION AND CONTROL PROGRAM and has no information on COVID-19. Another policy labeled EMERGENCY OPERATIONS PLAN for COVID-19 is not a step by step procedure on how to sanitize the facility. This policy was taken from another manual, generic and not detailed to their facility. For example, staff are to follow PPE protocol depending on isolation. Place labels on bottles to ensure the correct chemical is being used. On 7/7/2020 at 9:35 AM during facility tour, R1 was seen in room [ROOM NUMBER] on bed. V3 (Registered Nurse) stated that R1 is on isolation due to being positive with Coronavirus. On the floor was a clear plastic bag full of linen which according to V10 (Certified Nursing Assistant) was the linen that was used by R1 when she was doing bedside care. V10 then took the bag with used linen and put it on the bin outside R1's room. On 7/7/2020 at 9:40 AM. V3 (Registered Nurse) stated, I am not sure what is inside the bag. But it should not be on the floor. I will ask V10 (Certified Nursing Assistant) about that bag. On 7/7/2020 at 10:05 AM. V11 (Registered Nurse / Infection Preventionist) stated garbage bag or linen bags inside rooms that have infection such as contact or droplet precautions and that where used linens should not be place on the floor. It should be placed on the stand and not touching the floor. Then when needed for laundry it must be double bagged sealed and brought directly to the laundry room. For Covid-19 positive residents we always used the red biohazard bag. And it should be double bagged before transporting. On 7/7/2020 at 10:15 AM. V10 (Certified Nursing Assistant) stated, when I was asked to perform care to R1, I placed all the used linens into that bag. I know I should not have left it on the floor. After my attention was called by V3 I placed the bag in the bin. The bin is being used for all residents on the 1st Floor. I should have separated R1's linen from other residents. On 7/7/2020 at 11:45 AM. V2 (Director of Nursing) stated that nursing staff should use proper procedure for handling of laundry. Per facility policy, linens that are used inside residents rooms with infection whether droplet or contact should not touch the floor. And biohazard bags that are colored red are used instead of the usual transparent bag. It must also be double bagged and must be transported directly to laundry. Policy and Procedure on Laundry - Infection Control reads: Double bagging using biohazardous bags of all bed and resident isolation linen is required. In Laundry, water soluble bags are utilized when isolation precautions are implemented. Staff will remove soiled laundry from the isolation container in the isolation room and transport the isolation in the isolation bags and hand them to Laundry Personnel. Isolation laundry will be washed separately from all other Laundry.