STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145996	A. BUILDING _____ B. WING _____	**05/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKRIDGE HEALTHCARE CENTER	**323 OAKRIDGE AVENUE HILLSIDE, IL 60162**

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)
E 0024 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Establish policies and procedures for volunteers.** Based on document review and interview, the facility failed to develop and implement policies and procedures for emergency staffing strategies and the use of volunteers, including the use of State and Federally designated health care professionals during an emergency event such as COVID-19. This deficient practice had the potential to affect approximately 54 residents in the facility. During an interview with the Director of Nurses (DON) on 5/27/20 at approximately 10:30am, a request was made for the facility's emergency preparedness policies and procedures specific to the required information listed above. The DON was unable to show evidence that the facility had developed and implemented emergency policies and procedures related to staffing strategies, the use of volunteers or the use of State and Federal health care professionals.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** Based on interview and record review, the facility failed to ensure that policies and procedures for an infection prevention and control program had been specifically developed and designed to provide a safe, sanitary and comfortable environment, and to help prevent the development and transmission of COVID-19. This had the potential to affect approximately fifty-four residents in the facility. Findings include: During the entrance conference with the Director of Nursing (DON) on 5/27/20 at approximately 10:30am, the infection control policy and procedure manual was requested. At approximately 1pm, the DON presented two folders to the surveyor. One folder contained the general infection control surveillance folder and the other folder contained only one specific infection control policy related to COVID-19. When asked if there were any other policy and procedures related to the prevention of COVID-19, the DON stated I have them in the computer, I will print them. Review of the policy and procedures given to the surveyor by the DON on 5/27/20 at approximately 1:30pm, revealed that policies and procedures had not been specifically developed and/or planned to guide staff to meet the needs of residents who may present signs and symptoms of COVID-19. Review of the documents and validation by the DON revealed that the policies and procedures were not designed to the facility and/or developed to assist staff in treating COVID-19 residents. Review of the forms revealed they were general guidelines from: the Illinois Department of Public Health; guidance from the Centers from Medicare & Medicaid Services; an untitled and undated document related to summarized data from multiple sources such as the World Health Organization (WHO) and Canadian Guidelines regarding Personal Protective Equipment (PPE); an Interim Guidance on Alternative Facemask from the Minnesota Department of Health; a Universal Mask Policy from Nebraska Medicine; an undated Competency Checklist for Donning PPE; an undated Quality Assurance Audit Tool for Handwashing; and an undated Resident Syndromic Surveillance form for COVID-19; and an Self-Monitoring of Asymptomatic Healthcare Personnel form. Review of documents provided by the DON revealed an absence of policies and procedures specific to mitigating COVID-19 infections in the facility that included, but were not limited to: the requirement to restrict visitors and non-essential health care personnel, cancellation of communal dining and all group activities, incorporation of face masks and social distancing for residents, implementation of active screening of residents and staff for fever and respiratory symptoms, procedures for transporting residents to the hospital in a manner to minimize transmission of the coronavirus, procedures for managing new admissions and readmissions from the hospital, the requirement for more frequent disinfection of high-touch surfaces as recommended by CMS and CDC guidance related to preparation for COVID-19 in nursing homes.

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.