STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145237	A. BUILDING _____ B. WING _____	07/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GENERATIONS AT REGENCY	6631 MILWAUKEE AVENUE NILES, IL 60714

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 observations, interviews, and record reviews the facility failed to follow their protocols for containing the spread of COVID-19 by not performing hand hygiene and storing face towels in a sanitary environment; they failed to follow their readmission policy as it relates to potential exposure to COVID-19; and they failed to follow Environmental Protection Agency (EPA) recommended usage guidelines for disinfection of high touch surfaces. These failures have the potential to affect all 168 residents currently in the facility. Findings include: 07/27/20 at 11:25AM observed a pile of face towels laying on top of an emergency cart in the 4th floor hallway with R9 sitting directly next to the cart. V5 (Nurse Supervisor - Registered Nurse) stated she was not sure if the towels were clean or soiled but they should not be sitting there. V5 then removed the towels from the cart, bagged them, and took them to be laundered. 07/27/20 11:49AM observed V4 (Infection Preventionist - Registered Nurse) touch R7's clothed shoulder and back then proceeded to grab a blood pressure equipment mobile stand without performing hand hygiene. Then at 11:53AM, observed V4 (Infection Preventionist - Registered Nurse) adjust R7's face mask and then touch a nurse's cart without performing hand hygiene. 07/27/20 11:55AM observed V8 (Certified Nursing Assistant) put a mask on R8's face, assist him with his wheel chair leg rests, then proceed to other nursing duties without performing hand hygiene. 07/27/20 at 12:01PM observed V4 (Infection Preventionist - Registered Nurse) adjust his face mask and adjust his goggles multiple times then proceed with nursing duties without performing hand hygiene. 07/27/20 at 1:25PM V3 (Director of Nursing) stated that hand hygiene should be performed after coming in contact with high touch surfaces, entering and exiting resident's rooms, and after adjusting facial PPE (Personal Protective Equipment). V3 stated if a pile of towels were left on a crash cart in a hallway they should be bagged and laundered. V3 stated that residents may take a towel from the pile believing they are clean when they may not be and the resident may potentially become contaminated. 07/28/20 at 10:45AM - 11:25AM V3 (Director of Nursing) stated nursing staff should perform hand hygiene as soon as possible after doffing or touching PPE (Personal Protective Equipment) for the face. V3 stated she wouldn't want to see staff doff or touch facial PPE and then proceed to touch other surfaces or proceed with nursing duties without first performing hand hygiene. V3 stated that this is not the best practice. V3 stated it is difficult keeping staff from these behaviors but staff are educated on the spot when this is observed. The facility's COVID-19 response policy (undated) states: Ensure staff are educated on and correctly performing hand hygiene, donning and doffing of PPE. R6's physician order [REDACTED]. R6's progress note dated 07/17/20 documents R6 returned to the facility from receiving medical services at another location. 07/28/20 at 12:30PM V3 (Director of Nursing) stated that R6 was originally placed in same room as R5 on 07/01/20. At this time, R5 was not in a COVID designated room (observation or positive). R5 is an [AGE] year old male admitted to the facility on [DATE] with a BIMS (Baseline Interview for Mental Status) score of 15. R5 has [DIAGNOSES REDACTED]. R5's physician order [REDACTED]. This was from R6 having been assigned to the same room with R5. R5's progress notes dated 07/17/20 documents R5 was notified and educated he will be on 14 day droplet precautionary isolation per facility protocol. Resident verbalize understanding. 07/28/20 at 10:45AM - 11:25AM V3 (Director of Nursing) stated that when R6 was received back into the facility from outside medical services 07/17/20 transportation personnel brought R6 right back to the room he shared with R5 (prior to leaving from the facility). Because R6 had already crossed the threshold of the room with R5, R5 then had to also be placed on isolation. V3 stated after this incident it became required that emergency medical staff or transportation personnel must now obtain room assignments for residents at the reception area before placing residents back in their room. V3 stated this practice was implemented a couple of weeks ago after the incident with R5 and R6. V3 stated the facility keeps a list of everybody going out to appointments so when they return to the facility rooms will already be available for them. V3 stated the staff does their best to keep the residents isolated from those who are under observation for COVID. The facility's policy for readmissions from an acute care setting received 07/28/20 states: Returning residents under investigation for COVID-19 who are ready for hospital discharge but do not have test results available should be discharged to a skilled long-term care facility following the CDC's (Centers for Disease Control) guidance for when Transmission Base Precautions are required. The CDC's (Centers for Disease Control) guidance for Responding to Coronavirus (COVID-19) in Nursing Homes updated 04/30/20 and accessed 07/28/20 states: Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19. 07/27/20 at 11:36AM V11 (Housekeeping Aid) stated that he conducts environmental cleaning once during shift and as needed. V11 stated that he uses a green and yellow cleaner to clean the rooms and high touch surfaces. 07/27/20 at 1:37PM V9 (House Keeping Supervisor) stated that housekeeping staff uses a green colored product and it has a contact time of 10 minutes. V9 stated the green colored disinfectant is also a cleaner and it is diluted with water and placed in a dispenser for use. V9 stated that environmental cleaning is done once in the morning and as needed in the afternoon. V9 stated that high touch areas are cleaned every 2 hours. V9 stated that surfaces are cleaned in order of back to front high and high to low in rooms then the bathroom is cleaned last. V9 stated the yellow cleaner and disinfectant is used for high touch surfaces in hallways and for isolation rooms for highly pathogenic organisms. V9 stated only the green and yellow colored products are used for disinfectant and cleaning purposes by housekeeping staff. 07/27/20 12:38PM observed V10 cleaning the railings and elevator buttons in the first floor hallway with a green colored product. Observed V10 spray surfaces with the green colored product and immediately wipe them down. V10 stated that the chemical in the spray bottle is a cleaner and disinfectant according to V9 (House Keeping Supervisor). V10 stated that he cleans the facility environment once a day and as needed. Cleaning and disinfectant instructions received from the facility 07/28/20 for the yellow colored product used by housekeeping staff for environmental cleaning of high touch surfaces states that for human coronavirus treated surfaces must remain wet for 1 minute. Cleaning and disinfectant instructions received from the facility 07/28/20 for the green colored product used by housekeeping staff for environmental cleaning of high touch surfaces states treated surfaces must remain wet for 10 minutes. The green colored product does not list human coronavirus as an organism the product is effective against. The green and yellow colored products were not included in the EPA (Environmental Protection Agency) list N of approved disinfectants for use against [DIAGNOSES REDACTED]-CoV-2 (COVID-19). The facility's COVID 19 response policy received 07/27/20 states: Facility will disinfect frequently touch surfaces as frequently as possible (recommend every 2 hours when possible) with EPA registered and approved product (List N products). Facility will educate and observe practice on appropriate disinfection (clean to dirty, appropriate dwell time, when to switch clothes and wipes, etc.). Ensure cleaning and disinfection policies and procedures are being followed consistently and correctly.

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.