STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145208	A. BUILDING _____ B. WING _____	04/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIDGEVIEW HEALTH CARE CENTER	8100 SOUTH HARLEM AVENUE BRIDGEVIEW, IL 60455

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 record review and interview, the facility failed to include how ancillary staff and or volunteers were used to mitigate staffing shortages during COVID-19 outbreak. This deficient practice had the potential to affect all 108 residents in the facility. Findings include: Review of the facility's emergency preparedness plan and staffing strategies dated 3/20/2020 revealed: Staffing - During Outbreak POLICY To ensure facility has adequate staffing so resident care is not disrupted during the outbreak. PROCEDURE Human Resources and/or scheduling under the direction of the Administrator and Director of Nursing are responsible for scheduling and assembling adequate staff. Scheduler/HR working with the DON will strive to keep consistent staff assigned to care for residents with COVID-19. The following steps will be taken. Scheduler/HR will maintain current information on all personnel with addresses and phone numbers for contact purposes. This information is update on a routine basis Scheduler/HR coordinates with department heads to determine staff needed. Scheduler/HR keeps department heads and Administration informed with the results of attempts to obtain staff. Scheduler/HR follows up and confirms as needed for expected availability of the staff. Scheduler/HR as needed will assist/coordinate staff with transportation to work Scheduler/HR will monitor the length of time each employee works to provide adequate time off to rest and recover. If necessary, the scheduler/HR in coordination with the administrator will work with agencies and/or sister facilities to obtain additional staff. ANCILLARY HEALTHCARE STAFF-restricted at this time Ancillary healthcare staff may include: students, lab, EMS providers, hospice workers, etc.) Ancillary healthcare staff are not considered visitors. They are treated the same as facility staff. They complete the screening and have their temperature taken prior to admission. Any yes answers or a temp over 100 degrees and they are sent home. CRISIS STRATEGIES TO MITIGATE STAFFING SHORTAGES: Nurses Aides that have completed the certified nursing assistant course but have not taken the certification test may work past the four months if they have successfully completed competencies reflecting the care and services they provide for our residents . The facility's plan indicated that ancillary staff were restricted but did not include how to use the ancillary staff and/or volunteers to mitigate staffing shortages in case staff are not able to report to work or need to be replaced while at work due to sickness. Review of the facility's resident roster and surveillance tracking indicated a 22-bed COVID 19 designated unit. At the time of the survey, the unit had 14 residents who were on droplet/contact precautions. During an interview on 4/14/2020 at 11am, the Administrator confirmed the facility's staffing strategy did not include how to utilize the ancillary staff during staffing shortage.
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 failed to follow practices to contain the spread of COVID-19 as evidenced by failure to implement the use of personal protective equipment (PPE); and, handle clean and soiled linens to prevent potential transmission of infection. This deficient practice had the potential to affect all 108 residents in the facility. Findings include: During an interview with the Administrator and Assistant Director of Nursing (ADON) on 4/9/ at 9:41am, both indicated they had have positive cases of COVID 19 in house. The Administrator stated that they designated a separate unit for suspected and confirmed COVID 19 cases separated by fire doors in the third floor. Review of the room roster revealed that Rooms 315-1 to 332-2 (22 total beds) were designated as the COVID 19 unit. Review of the list indicated there were 14 residents under droplet/contact precautions. 1. Fourth Floor Observations: Observation on 4/9/2020 at 10:20am revealed LPN1 (Licensed Practical Nurse) in front of the computer in the nurses' station with the facial mask off her nose and mouth. When asked why the mask was not properly applied, LPN1 stated she was not in a resident care area and just got off the phone. At 11am in the hallway front of room [ROOM NUMBER], NA1 (Nursing Assistant) was observed not wearing a facial mask. When asked why she was not wearing a mask, NA1 stated that the mask got soiled after taking care of Resident1 (R1) in room [ROOM NUMBER] (droplet/contact precautions). When the surveyor told NA1 to go and get a replacement right away, NA1 stated she was on her way to take a break and would do it. However, before she left for her break, NA1 entered a non-isolation room (room [ROOM NUMBER]) without a mask. During the same observation, a clean linen cart in the hallway between room [ROOM NUMBER] and room [ROOM NUMBER] was observed uncovered. NA1 covered it when the surveyor asked if it should be covered. In the hallway near room [ROOM NUMBER], a soiled linen hamper was observed with soiled linens exposed and not contained in a plastic bag. When asked if it (soiled linens) should be contained, Registered Nurse1 (RN1) stated it should be and that he would inform the NAs about it. 2. Third Floor Designated COVID-19 Rooms 315-332 Observations: On 4/9/2020 at 11:55am, NA2 who was wearing a facemask and carrying a lunch tray entered a partially opened room [ROOM NUMBER] without donning goggles or gown. NA3 who was already in the room serving a lunch tray for the resident in bed two, informed NA2 that she should have put on a gown. NA3 told NA2 to just leave the tray on top of the dresser and leave. When NA2 left the room, the surveyor asked NA2 why she entered the room without donning a gown. NA2 stated she did not know that the residents in the room were on contact/droplet precautions. Review of the POS [REDACTED]. NA4 was wearing a face mask and a face shield and an isolation gown. However NA4's gown was untied at the back exposing his uniform. When asked if he should have tied the gown to protect his uniform, NA4 stated yes. When asked if he had assigned residents outside of the COVID 19 unit, NA4 stated yes. During an observation of the supply room with the ADON on 4/9/2020 at 1:52pm, there was no N95 respirator masks available. The ADON stated the N95 respirator masks were ordered but had not arrived yet. Review of the facility's policy titled BRIDGEVIEW ADMITTING AND CARING FOR A RESIDENT WITH A [DIAGNOSES REDACTED].We have designated room's (sic) on third floor to be the facility designated COVID 19 unit. This unit is separated from non-symptomatic residents. If the COVID unit expands to more than 2 room's (sic) it will be separated from the other rooms on the floor by the fire doors .3. Signage will be posted outside the room stating Droplet and Contact precautions in addition an Isolation cart will be placed at entrance of room . 7. All staff will wear PPE when caring for the resident . Further review of facility's policy/procedure titled PPE DURING COVID-19 PANDEMIC- revised as of 4/8/20 revealed: POLICY During the COVID-19 pandemic PPE is in limited supply but high demand. To meet the CDC guidelines for use of PPE the facility has instituted the following protocols. 4/3/20 Knowledge regarding COVID-19 is rapidly expanding. Due to continually evolving evidence, our face mask policy is changing. We have instituted a universal face mask policy per IDPH guidelines. While staff or visitors are in the facility they are to wear a face mask. This includes staff responsible for direct interaction or care involving residents as well as staff who do not normally interact directly with patients and residents, such as administrative, dietary, environmental services, and facility maintenance staff . PPE is available in resident care areas Staff wear the following PPE when caring for residents with symptomatic or diagnosed respiratory illness. Gloves Isolation gown Facemask Eye protection (e.g., goggles or face shield) . According to: https://www.cdc.gov/coronavirus/2019ncov/downloads/A_FS_HCP_COVID19_PPE.pdf Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19 indicated that .PPE must be donned correctly before entering the patient area (e.g., isolation room, unit if cohorting) .PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas . According to:

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) https://www.cdc.gov/infectioncontrol/guidelines/environmental/background/laundry.html .Contaminated textiles and fabrics often contain high numbers of microorganisms from body substances, including blood, skin, stool, urine, vomitus, and other body tissues and fluids. When textiles are heavily contaminated with potentially infective body substances, they can contain bacterial loads of 106-108 CFU/100 cm2 of fabric.1247 Disease transmission attributed to health-care laundry has involved contaminated fabrics that were handled inappropriately (i.e., the shaking of soiled linens). Bacteria (Salmonella spp., Bacillus cereus), viruses ([MEDICAL CONDITION] virus (HBV)), fungi (Microsporum canis), and ectoparasites (scabies) presumably have been transmitted from contaminated textiles and fabrics to workers via a. indirect contact or b. Aerosols of contaminated lint generated from sorting and handling contaminated textiles . Contaminated textiles and fabrics are placed into bags or other appropriate containment .; these bags are then securely tied or otherwise closed to prevent leakage. Single bags of sufficient tensile strength are adequate for containing laundry, but leak-resistant containment is needed if the laundry is wet and capable of soaking through a cloth bag . According to: https://americanlaundrynews.com/articles/keeping-laundered-textiles-clean-during-storage-transport-conclusion .Be sure to clean transport or distribution carts with a hospital-grade disinfectant prior to loading the carts with the clean linens. Cover the carts to keep the linens from airborne contaminants. Enclosing the linen from the bottom up helps keep the linens clean, depending on the cart manufacturing. If it's a mesh-like cart, the wheels can kick up dirt, water, etc .