STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145268	A. BUILDING _____ B. WING _____	**06/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GLENVIEW TERRACE NURSING CTR	**1511 GREENWOOD ROAD GLENVIEW, IL 60025**

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.** Based on observation, interview and record review, the facility failed to properly contain COVID-19 by failing to follow infection control protocols by not donning and doffing PPE (Personal Protective Equipment) as required, not performing hand hygiene prior & during resident care. This failure affects seven residents (R1-R7) reviewed for infection control and prevention. Findings include: 06/01/20 at 11:35AM Observed R3 sitting in wheel chair wearing a face mask in hallway of 3rd floor memory care unit waiting to be served lunch. V7 (Special Care Program Coordinator) adjusted his face mask over the bridge of his nose twice and did not perform hand hygiene afterwards. R3 removed his face mask. V7 reminded R3 that he needed to keep his facemask on then without performing hand hygiene, assisted R3 with putting on his face mask. 06/01/20 at 12:15PM Observed V10 (Dietary Aid) in 3 East memory care hallway with the top of his mask laid over the tip of his nose not completely covering it. 06/01/20 at 12:20PM Observed V9 (3 East Unit Director) leaning closely to R3 while speaking with him and her mask was not covering her nose. The top of V9's mask rested over the tip of her nose and while speaking with R3 moved under the base of her nose repeatedly. R3's Care Plan documents he is being treated with oxygen due to shortness of breath effective 05/19/2020 and he is at risk for COVID. Interventions include: Educate all staff, residents, family, and visitors about COVID-19 signs and symptoms and precautions. 06/01/20 at 12:25PM Observed V7 (Special Care Program Coordinator) adjust his face mask while feeding R6; V7 then continued feeding R6 without performing hand hygiene after touching his own face mask. 06/01/20 at 12:26PM Observed V9's (3 East Unit Director) face mask not covering her nose while speaking with and assisting R4 to her room. While in close proximity speaking with and escorting R4 to her room, the top of V9's mask laid across the tip of her nose and when speaking moved under the base of her nose repeatedly. R4's Current Care Plan documents R4 is at risk for COVID. Interventions include: Educate all staff, resident, family, and visitors about COVID-19 signs and symptoms and precautions. 06/01/20 at 12:42PM Observed V8 (Certified Nursing Assistant - CNA) grab both of her pant legs to adjust them before sitting down with R5 to feed her. V8 began feeding R5 after touching her clothes without performing hand hygiene. 06/01/20 at 11:45AM V9 (3 East Unit Director) stated that face masks should be adjusted from the outer edge of the mask or the ear loops but not the outside of the mask because it could be contaminated. V9 stated that hand hygiene should always be performed by staff after touching any part of their face masks. V9 stated that the most recent in services given for proper use of PPE and hand hygiene were last week and staff education on these topics are provided daily. 06/01/20 at 12:05PM V7 (Special Care Program Coordinator) stated that hand hygiene should be performed after touching or adjusting face masks. V7 stated that education on when to perform hand hygiene is provided daily by the facility. 06/01/20 1:02PM - V9 (3 East Unit Director) stated that if face masks do not completely cover the nose there is a possibility of spreading germs. V9 stated that she always feels her mask sitting over the tip of her nose and her masks does move below her nose while she's speaking. V9 stated she has to constantly readjust her mask. V9 stated that if she forgets to readjust her mask and it is not covering her nose completely she would need to speak with her supervisor to get a new mask and there would be a concern for contamination of the residents she encountered while working. 06/02/20 at 1:50PM V2 (Infection Preventionist) stated that competency scales are done with staff in each department for PPE procedures and return demonstrations are conducted. V2 stated that all staff were in serviced on how to correctly wear masks. V2 stated that masks are worn to protect staff and residents from infection. V2 stated that hand hygiene must be performed immediately by staff after touching their clothes or making any adjustments to their face masks. 6/1/2020 at 12:33PM V4 (Licensed Practical Nurse - LPN) was observed taking an insulin pen from medication cart on COVID-10 positive unit, and walked into a resident (R7's) room, she came out of the room minutes later and placed the insulin pen back in a plastic bag and put it back in her cart without any type of disinfection. At 12:45PM, R7 was moved to a non-COVID-19 unit. V4 then grabbed all of R7's medications, including the insulin pen, from the medication cart and took them to the non-COVID-19 floor. V4 did not change her face mask when going from the COVID-19 floor to the non-COVID-19 floor. At 12:56PM, V4 stated that she was supposed to remove everything including the mask before leaving the COVID-19 area and that she had forgotten to do so. 6/1/2020, while observing the activities on the COVID-19 unit, two housekeepers (V5 and V6), were observed cleaning an empty room and both of them were going back and forth from the COVID-19 positive section to other units without changing their face masks. At 12:54PM, V5 and V6 stated that they removed their gowns and gloves, but not their masks when moving from the COVID-19 positive area to other parts of the facility. At 2:26PM, V1 (Director of Nursing - DON) stated that the used insulin pen should be disinfected before being put back in the cart, even without COVID-19 and that all staff are supposed to remove all PPE, including facial masks when leaving the COVID-19 unit and going to other parts of the facility. Facility COVID-19 Preparedness and Management Policy (Updated 5/11/2020) includes: The facility has educated staff on proper use of PPE equipment. Facility Policy for Hand Hygiene (revised 3/2020) includes: Hand hygiene should be performed after touching contaminated surface or objects.

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