STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145875	A. BUILDING _____ B. WING _____	05/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WARREN BARR LINCOLN PARK	2732 NORTH HAMPDEN COURT CHICAGO, IL 60614

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 -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the unprecedented coronavirus global pandemic that resulted in the Presidential declaration of a State of National Emergency dated 3/13/20, the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) Memo QSO-20-14-NH revised on 3/13/20, Nursing Home guidance from the Centers for Disease Control (CDC), and observation, interview, and record review, the facility failed to ensure staff followed appropriate standard and transmission based infection control practices to prevent the spread of COVID-19. This failure had the high likelihood to affect the six residents (R5, R6, R7, R8, R9 and R10) who were primarily under the care of one Nursing Assistant (NA1). R7, R8, R9 and R10 were PUIs (Persons under Investigation) and did not have definitive [DIAGNOSES REDACTED]. The IJ began on 5/5/20 at approximately 11:40am, when NA1 entered the room shared by R1, R2, R3, and R4, all diagnosed with [REDACTED]. NA1 did not remove her universal gown and did not don an isolation gown before she entered the isolation room. After approximately 15 minutes, NA1 exited the room without removing the universal gown and proceeded to where the dietary cart was located at the end of the hall. The surveyor informed the Director of Nursing (DON) about the observation, who immediately told NA1 to remove her universal gown which was considered contaminated. The facility had 10 residents positive for COVID-19 that were currently residing in the facility and nine PUIs at the time of this survey. The facility was located in a county with sustained community transmission, with many active COVID-19 cases and deaths. Findings include: According to the Centers for Disease Control and Prevention (CDC), Given the high risk of spread once COVID-19 enters a nursing home, facilities must take immediate action to protect residents, families, and healthcare personnel (HCP) from severe infections, hospitalization s, and death .Dedicate Space in the Facility to Monitor and Care for Residents with COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19. Assign dedicated HCP to work only in this area of the facility .Resident with new-onset suspected or confirmed COVID-19. Ensure the resident is isolated and cared for using all recommended COVID-19 PPE. Place the resident in a single room if possible .Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes- responding.html. During an entrance interview on 5/5/20 at 11:10am, with the Administrator and the Director of Nursing, when asked whether the facility had positive cases of COVID-19, the Administrator stated, Yes, we have some residents on the second floor. The DON added, I think we have eight COVID-19 positives and some PUIs. The DON further stated, Our second floor is our COVID-19 floor. When asked for their personal protective equipment (PPE) inventory. The DON responded, We have a lot. We recently received supplies from our corporate office. The DON further stated that the facility also received PPE from the Chicago Public Health Department. On 5/5/20 at approximately 11:40am, NA1 entered the room shared by R1, R2, R3 and R4 all diagnosed with [REDACTED]. NA1 immediately closed the door after she entered the room. A few minutes later LPN1 (with complete PPE) was observed to enter the same room to administer R3's medication. At approximately 11:55am, NA1 exited the room without removing the universal gown. NA1 proceeded to walk towards the end of the hallway where the dietary cart was located and was about to deliver the lunch trays. The surveyor informed the DON (who was also on the floor) about the observation; the DON then told NA1 to remove her universal gown since she had worn it into a room with positive COVID-19 residents. On 5/5/20 at approximately 12:10pm, LPN1 was asked about the observation. LPN1 stated, When I saw (name of NA1) inside the room without the proper PPE, I immediately told her to go out of the room and change into an isolation gown. LPN1 continued, But she did not listen to me. When asked whether staff had to reuse gowns, masks, and or googles. LPN1 stated that they did not and stated that the facility had enough PPEs. On 5/5/20 at approximately 12:20pm, the DON stated, They have been in-serviced on proper donning and doffing of PPE including when to use the isolation gown. The DON confirmed, NA1 should have changed into an isolation gown before she entered the isolation room, we have the sign and the set up outside the room. The DON added, It's not like we do not have available PPE's, we have enough. The DON was asked whether all the residents on the unit were COVID-19 positive or PUIs. The DON explained that one resident was on contact isolation due to ESBL (Extended Spectrum Beta Lactamase) infection of the urine and the remaining residents were not on any kind of isolation and not considered PUIs. When asked what her thoughts were knowing that not all residents had the same infectious disease. The DON stated, I know, I totally understand the risk (of transmission), especially with COVID. Below were the record reviews of the four residents diagnosed with [REDACTED]. 2. Review of R2's EHR under Progress Notes revealed, R2 was readmitted to the facility on [DATE] at 5:30pm from an acute care hospital with admitting [DIAGNOSES REDACTED]. 3. Review of R3's EHR under Progress Notes revealed, R3 was readmitted to the facility on [DATE] at 9:30pm from an acute care hospital with admitting [DIAGNOSES REDACTED]. 4. Review of R4's EHR under Progress Notes revealed, R4 was readmitted to the facility on [DATE] from an acute care hospital with admitting [DIAGNOSES REDACTED]. On 5/5/20 at approximately 1:35pm, NA1 was asked about the observation. NA1 stated, I am so sorry, I know I was wrong. NA1 further stated, I should have changed to a new gown before entering the room. NA1 explained that she was only talking to NA2 about a misunderstanding with another staff member. NA1 claimed she was nowhere near the residents. When asked what the process was before entering the room of a COVID-19 positive resident. NA1 described, Before we go up (to the units), we are given this blue (universal) gown, mask and other PPE. The universal gown is the one we use anywhere in the facility. NA1 continued that staff would remove the universal gown, hang it up on the hook outside the room, change into an isolation gown, enter the room, do the cares and discard the isolation gown and gloves before exiting the contact/droplet isolation room. NA1 was further queried whether there was a time when staff had to reuse PPE. NA1 stated, No, I do not think so. Review of NA1's room assignment indicated NA1 was assigned to rooms 210-215 on 5/5/20. When asked how many residents were under her care. NA1 verbalized that she had six residents namely R5, R6, R7, R8, R9 and R10. NA1 stated that although she was primarily assigned to the aforementioned residents she would still help other residents as needed. NA1 explained that staff were expected to help all residents whether they were assigned to them or not. On 5/5/20 at approximately 2:15pm when asked about the observation, NA2 (who was already in the room before NA1 entered) explained, I was busy with R2 when NA1 came inside the room. I know it was wrong for (name of NA1) to enter without changing into an isolation gown. When asked whether staff had reused gowns and other PPEs before, NA1 responded, No, we have not. We always have masks, gowns. Review of the facility's Resident Census List dated 5/5/20 for the second floor revealed the list were divided into four groups. There were ten residents with positives affixed next to their names, one resident on contact isolation due to ESBL, nine residents had PUI affixed next to their names and the remaining nine residents had blank next to their names. On 5/11/20 at 3:55pm, the DON confirmed that the last nine residents were not PUIs, not COVID positives nor did they have a different type of infection. The DON explained, They are no longer on the second floor, we moved some of them in another unit unless their results came back positive after we tested all the residents. Below were the record reviews of the six residents under NA1's care: 1. Record review of R5's EHR under Progress Notes revealed R5 had [DIAGNOSES REDACTED]. Further review of the entire EHR revealed R5 was not a PUI and did not have a definitive [DIAGNOSES REDACTED]. Record review of R6's EHR under Progress Notes revealed R6 had [DIAGNOSES REDACTED]. Further review of the entire EHR revealed R6 was not a PUI and did not have a definitive [DIAGNOSES REDACTED]. Record review of R7's EHR on 5/5/20 under [DIAGNOSES REDACTED]. 4. Record

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) review of R8's EHR on 5/5/20 under [DIAGNOSES REDACTED]. 5. Record review of R9's EHR on 5/5/20 under Progress Notes revealed R9 had [DIAGNOSES REDACTED]. Review of the CDC's Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings revised on 4/13/20 under 2. Adhere to Standard and Transmission-Based Precautions revealed, .HCP (see Section 5 for measures for non-HCP visitors) who enter the room of a patient with known or suspected COVID-19 should adhere to Standard Precautions and use a respirator (or facemask if a respirator is not available), gown, gloves, and eye protection. Review of the CDC's guidelines titled, Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19 dated 3/30/20 revealed, How to Put On (Don) PPE Gear. More than one donning method may be acceptable. Training and practice using your healthcare facility's procedure is critical .2.Perform hand hygiene using hand sanitizer. 3. Put on isolation gown. Tie all of the ties on the gown .Further review of the same document revealed, Doffing (taking off the gear) .2. Remove gown. Untie all ties .Reach up to the shoulders and carefully roll the gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle. 3. HCP (Healthcare Personnel) may now exit the room . Based on the facility's COVID-19 Guidelines and Emergency Preparedness revised on 4/30/20 under C. Isolation revealed, Suspect PUIs. Patients should be asked to wear a surgical mask .Airborne infection isolation room (AIIR) or formerly negative pressure room. In LTC setting, the AIIR is not applicable but the patient should be isolated in a room if the respiratory illness is undiagnosed and placed on Standard, Contact, and Droplet Precaution. Healthcare personnel entering the room should use Standard, Contact, Droplet Precautions, and use eye protection . The Administrator and the DON were notified that the immediacy was removed on 5/11/20 at 4:27pm after the surveyor verified (through observation and interview) implementation of an acceptable removal plan that included the following: 1. Formally in-serviced NA1 on proper donning and doffing of PPE especially the importance of removing PPE prior to leaving the room followed by hand hygiene. 2. In serviced all staff on all shifts regarding infection control protocol including donning and doffing of PPE when leaving the isolation room. 3. The DON provided a list of residents on isolation for positive COVID 19 and a list of PUIs with undiagnosed respiratory illness to ensure that if staff were in the isolation room of a COVID positive resident, they remove their PPEs before exiting the room and before caring for other residents, including the PUIs with undiagnosed respiratory illness. After removal of the Immediacy, the non-compliance remained at the level of no actual harm with the potential for more than minimal harm that is no Immediate Jeopardy until sustained compliance is verified.