STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145711	A. BUILDING _____ B. WING _____	06/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEXINGTON OF ELMHURST	420 WEST BUTTERFIELD ROAD ELMHURST, IL 60126

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 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: (1) staff wore masks, (2) staff properly observed social distancing; and (3) linens were stored and transported in a sanitary manner. Findings include: According to the CDC's Key Strategies to Prepare for COVID-19 in Long-Term Care Facilities (LTCFs) last reviewed 6/12/20 under Prevent spread of COVID-19 indicated, Actions to take now: Cancel all group activities and communal dining. Enforce social distancing .Ensure all HCP wear a facemask or cloth face covering for source control while in the facility. Cloth face coverings are not considered personal protective equipment (PPE) because their capability to protect healthcare personnel (HCP) is unknown. Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required . Retrieved on 6/22/20 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html 1. During an entrance interview on 6/15/20 at 11:30am, the Administrator and the Director of Nursing were asked whether the facility had positive cases of COVID-19. The DON stated the facility currently did not have any positive cases and only had two residents on 14-day observation. The DON further explained that the two residents were newly admitted from the hospital. When asked for their personal protective equipment (PPE) inventory. The Administrator responded, We have enough. The DON added, We have regular delivery of PPE and our current census is low. 2. During an observation in the laundry room on 6/15/20 at approximately 12:30pm, with the Laundry Supervisor (LS) the following were observed: A. E1 was observed folding linens on the linen table without a mask on. B. Standing next to E1 was E2 who was approximately three feet apart from E1. C. Linens were on top of a white one-gallon container near the doorway of the laundry room. The linens were not covered, touched the opened door and exposed to environmental elements. When asked whether the linens were clean. E2 responded yes, and stated that she was about to put the linens on the linen cart to be transported to the unit. D. Linens were also on top of another white one-gallon container next to an electric fan. The linens were not covered and some parts of the linen touched the electric fan and the wall next to it. The LS who also observed the occurrence moved the linen farther from the electric fan but to no avail. E. A plastic bag full of towels was also observed on the floor underneath the linen table. The LS was asked about the observations. The LS stated, (Name of E1) should have her mask on. The LS further stated, Everyone should wear their mask, no one is exempted. When asked about the linens not being stored properly, the LS did not provide an answer. The LS, however, explained that the towels underneath the table were extra and would be given to the housekeeping department for future use. 3. During an observation in the kitchen with the Administrator on 6/15/20 at approximately 1:20pm, E4 was observed standing at the preparation table in between two other kitchen staff members. E4 did not have her mask on and stood approximately two feet from the other two staff members. On the other side of the kitchen, E5 was observed to exit from a walk-in refrigerator and went to where the food cart was located. E5 did not have his mask on. E5 was also observed talking with another kitchen staff. Both were approximately three feet apart. The Administrator was informed of the observations. The Administrator verbalized that all staff were expected to wear mask and proceeded to approach the above mentioned staff members. On 6/15/20 at approximately 1:35pm the Dietary Manager (DM) was asked about the observation. The DM claimed staff were in-serviced to observe proper infection control practices which included wearing masks at all times and [MEDICATION NAME] social distancing. The DM stated the above-mentioned observations were not acceptable. 4. On 6/15/20 at approximately 1:45pm, E2 was observed waiting for the elevator in the basement. Next to E2 was a green linen cart not fully covered with clean linens exposed. E2 left the cart near the elevator and went back to the laundry room. At the same time, NA1 was also observed waiting for the elevator with linens on both hands. The linens were observed to directly touch NA1's upper body uniform. NA1 was asked what her name was and where she was headed. NA1 responded, I'm (name of NA1) and I am going back to the second floor. During this time, the elevator door opened, E3 came out of the elevator and NA1 immediately entered the elevator. E3 was asked about the linen cart not being fully covered. E3 explained. The zippers are broken. At this time, E2 came back with another green linen cart that was not fully covered, with linens exposed. Upon seeing this, E3 stated, The zippers on this one are also broken. When asked how long the zippers had been broken, both did not provide an answer. When asked what their process was when carts were in need of repair, E3 stated that they would inform their supervisor, however, she could not remember whether she had informed their LS about this particular concern. E2 was queried about NA1. E2 explained that NA1 came down earlier to the laundry room to get a set of linens needed to make a resident's bed. E2 was further asked whether she had seen how NA1 had carried the linens earlier. E2 responded, Yes and added that NA1 should not have hugged the linens close to her body. E3 nodded her head in agreement. Review of the facility's Linen Operations revised on 10/19 under Infection Prevention Requirements indicated, To minimize any possible airborne contamination of the clean linen, we're required to cover the clean linen carts with a compatible protective cover. Carts should remain covered at all times when they are being transported and stored on units .Let's make sure we're keeping our carts clean and looking good. Although the linen carts are used to transport clean linen, they're always being touched by facility staff and linen tech. It is crucial that clean linen delivery carts are cleaned with an approved disinfectant on a daily basis. Before using a cart, always check to make sure it is in good condition. There should be no tears in the cart cover, no damaged wheels, etc. Notify your manager if the cart or cover is not in good condition .

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.