| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | **146167** | A. BUILDING _____ B. WING _____ | **06/04/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **FOSTER HEALTH & REHAB CENTER** | **2840 WEST FOSTER AVENUE CHICAGO, IL 60625** |

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) |
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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to follow their policy on Infection Control and Prevention of Infection. The facility failed to have Personal Protective Equipment (PPE) readily available, failed to post isolation signs, and failed to maintain safe handling of clean linen for 2 of 15 (R3 and R4) residents on isolation in the sample of 4. This failure had the potential to affect all 31 residents residing in the facility. Findings Include: During the initial tour of Covid-19 unit on 06/02/2020 at 10:20 am, R3 was observed sitting in a chair by the bedside in the room, the room door was open, a large floor fan blowing. The clean linen room was observed to be directly across from R3's and R4's room. The laundry room door was observed open with a cart of linen that appeared to be clean. The cart did not have a covering over the linen or the flap pulled down over the clean linen. R4 was in the room and appeared to be sleeping, and did not respond when R4's name was called. R3 stated, I have that infection but I am feeling better. R3 stated R4 had just come from the hospital on yesterday (6/1/2020). Both residents were on isolation for Covid-19. There was no signage observed on the door or on the isolation cart outside the room. There was an empty plastic bin observed with no Personal Protective Equipment (PPE) in it. R3 was asked if they take vitals at least once a day, and if there was any personal equipment for taking vitals in the drawer. R3 opened the drawer and stated, Nope. Observation of the drawer and on top of the night stand concluded there was no personal vital equipment for R3 or R4 inside the room. During an interview on 06/02/2020 at 10:56 am, V3 (Nurse) was asked why the rooms had no signage on the doors related to isolations, and why all five isolation carts were empty. V3 did not respond and shrugged her shoulders. V3 was asked if she was the unit nurse who was responsible to ensure that the isolation carts are stocked with PPE. V3 stated, I wasn't aware this was my responsibility. V3 was asked where V3's PPE came from. V3 responded, Out of V2's (Director of Nursing-DON) office. V3 (Nurse) was asked if the linen in the room was clean and V3 stated yes. V3 was asked why the door was wide open with the linen being exposed by the fan and infectious diseases. V3 stated the door should be closed and tried to close the door. V3 then stated the door was broken. During an interview with V4 (Certified Nursing Assistant- CNA) on 06/02/2020 at 11:10 am, V4 was asked if V4 was responsible for taking vitals on the Covid-19 unit, V4 said yes. V4 went over and pulled out the cart in the hallway that had a blood pressure cuff and a thermometer and showed the container that is used to cleanse the blood pressure cuff. V4 (CNA) was asked if the Covid-19 residents had their own personal equipment for vitals; V4 stated no. V4 (CNA) was asked how staff gets their Personal Protective Equipment (PPE) if the isolation carts are empty. V4 responded, We get it from V2 (DON), it is in V2's office. During an interview with V2 (Director of Nursing) on 06/02/2020 at 10:56 am, V2 was asked why the clean linen room door was left open with clean linen in the room being exposed to air. V2 was asked about the fan in R3 and R4's Room (#109) blowing air directly across into the clean linen room. The bin holding the linen did not have a covering. V2 was also asked how long the door had been broken; V2 stated, I am not sure. V2 was asked about all five of the isolation carts that were empty with no PPE. V2 was asked to observe the isolation carts placed on the unit. V2 opened the carts and observed that they were empty. V2 stated, Oh no, can I show you something, can you come to my office, I have a lot of PPE in my office'. V2 was asked about the signage and stated, I will get that done right now. On 06/02/2020 at 11:15 am, while speaking with V2 (DON), V1 (Administrator) came onto the Covid-19 unit and inquired about what seemed to be the problem. V1 was informed about not having PPE on the unit and all 5 isolation bins are completely empty. V1 stated, Oh no, I don't believe that. V1 made observations to find all 5 bins empty. V1 was asked how the staff gets their PPE if it is not readily available to them and why there was no signage posted on the unit with 15 residents on isolation. V1 stated, I am sorry I need a minute please and walked away. Facility's Policy: Infection Control Program (revised with In-service 3/24/2020) Policy: The facility has established a policy to identify record, investigate, control and prevent infections in the facility. Once the infection is identified and necessitates isolation, the facility will decide what procedure should be applied to the resident, including what type of isolation should be put in place. The facility will also maintain a record of incidents and corrective actions implemented for the identified infections. Procedures: 4. If a resident develops an infection, the nurse will notify, the DON or designee so that the occurrence of infection can be recorded. The resident's attending physician will be notified to obtain treatment for [REDACTED]. A transmission-based precaution set up will be provided outside the resident's room to provide Personal Protective Equipment (PPE) like gown and gloves to staff and visitors entering the resident's room. 6. A sign will be provided outside the room for residents on transmission-based precautions. 7. A disposable thermometer, BP cuff and stethoscope will be provided inside the room to provide personal equipment for residents who are on transmission-based precautions. |

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