STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145126	A. BUILDING _____ B. WING _____	**05/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALDEN LINCOLN REHAB & H C CTR	**504 WEST WELLINGTON AVENUE CHICAGO, IL 60657**

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 that laundry was stored and transported in a sanitary manner, and staff followed proper infection control practices. These failures had the potential to affect all residents in the facility. 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 .Recent experience with outbreaks in nursing homes has also reinforced that residents with COVID-19 may not report typical symptoms such as fever or respiratory symptoms; some may not report any symptoms. Unrecognized asymptomatic and pre-symptomatic infections likely contribute to transmission in these settings .In addition to the actions described above, these are things facilities should do when there are COVID-19 cases in their facility or sustained transmission in the community. Action to take now .Enforce social distancing .Ensure all residents wear a cloth face covering for source control whenever they leave their room .Implement universal use of source control for everyone in the facility. On 5/13/20 at approximately 12:35pm, E1 was observed on the elevator next to an open blue vinyl laundry bin. Inside the bin were blankets, and hanging on the sides of the laundry bin were pants, blouses, sweaters, and t-shirts. When asked whether the aforementioned were clean, E1 responded, Yes, I am delivering them (laundry) to the residents. E1 was then observed to deliver laundry to the residents on the first floor unit. The laundry bin remained open the whole time E1 delivered laundry on the first floor. At one time, E1 took some clothes to room [ROOM NUMBER]. On her way to the room, the clothing touched E1's universal gown. At approximately 1pm, during the laundry tour with E1, the following were observed: 1. A long two-shelf table that was positioned directly next to the wall underneath a large industrial exhaust fan. The table was caked with dust and was piled high with uncovered pillows. E1 was asked about the observation. E1 stated, They (referring to the pillows) are clean for the residents. On the second shelf, piles of old, worn shoes were observed next to piles of clean linen blankets. Some blankets were wrapped loosely with clear plastic with some parts of the blanket exposed. Some blankets were not wrapped and were exposed to dust and other elements. E1 was asked about the shoes. E1 stated that the shoes had been there for a long time. The floor underneath the table was dusty, and had crumpled papers and wrappers on it. 2. Next to the above-mentioned long table was a wheelchair full of slings. E1 verbalized, They are clean. When asked about the wheelchair being used as storage, E1 just smiled and did not provide an answer. 3. Next to the laundry, was a laundry storage room. Inside the laundry storage room were two large blue laundry carts full of clean laundry that was not fully covered leaving the linen exposed. Next to the first laundry cart were uncovered, dusty, old wheelchairs and Geri-chairs. Within the same area was the linen folding table. On 5/13/20 at 1:20pm, the Administrator who later joined E1 and the surveyor was asked about the observation. The Administrator stated that staff should have kept the area sanitary and well kept. The Administrator explained that the shoes would be discarded since they had been there for the longest time. The Administrator was shown the dusty industrial fan right above the clean pillows. The Administrator stated that the pillows should have been covered and the industrial fan cleaned and free of dusty materials. On 5/13/20 at approximately 4:10pm, during an observation with the Regional Nurse Consultant (RNC) on the first floor outside room [ROOM NUMBER], a linen cart was observed uncovered with linens exposed. Furthermore, linens were observed on top of the said cart. When asked about the observation the RNC stated, This is not acceptable for infection control purposes. Review of the facility's Laundry Policy and Procedure revised on 6/18 under Procedure indicated, 3. Linen cart is to be covered during transporting of linen. Linen carts in hallways and alcoves will be covered at all times .6. Nursing will be responsible for maintaining linen storage closets and carts in clean condition to assure linen is protected against contamination .

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