STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145591	A. BUILDING _____ B. WING _____	**07/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESLEY PLACE	**1415 WEST FOSTER AVENUE CHICAGO, IL 60640**

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 -** Few	**Provide and implement an infection prevention and control program.** Based on interviews, observations, and records reviewed the facility failed to ensure staff followed their hand hygiene policy after touching high touched surfaces and removing personal protective equipment. This failure affected 3(R5, R6, R8) of 9 residents reviewed for infection control in the facility. Findings include: During an interview with V9(Nurse) on 7/21/20 at 10:15AM, V9 said isolation means droplet precautions when residents are in quarantine for 14 days. This means residents are kept in their rooms, staff wears gowns when entering residents rooms. Signs are posted on residents room door to alert staff. During an interview with V6 CNA(Certified Nurse Assistant) on 7/21/20 at 10:47AM, V6 said her training on COVID-19 prevention included using hand sanitizer or hand washing between all residents. V6 said she knows when a resident is on isolation by the sign on the door and must wear a gown when entering the room. On 7/21/20 at 11:45AM V10(CNA), observed on the first floor passing meal trays to resident rooms. V10 entered R6's room to deliver and set up the meal tray wearing a disposable blue gown. R6 had an isolation sign with images of staff wearing a gown to enter the room on the door. V10 placed the tray on the bedside table and adjusted the table to the resident's reach. At this time, she opened the milk, unrolled silverware, and removed the cover from the plate. V10 removed the disposable gown after delivering the tray, but did not perform hand hygiene. The hand gel station was located between R6's room and the food tray cart. V10 returned to the food tray cart and carried R5's meal tray to R5's room. R5's room had no isolation sign on the door. V10 touched the bedside table when she placed the tray on it and then uncovered the drinks and unrolled the silverware. The door was open during both deliveries and V10 could be seen. V10 did not perform hand hygiene while in the rooms after touching the bedside tables, a high touch surface. Shortly after leaving resident's room, V10 preceeded to leave the leave the unit. She did not hand wash or perform hand hygiene She pressed the elevator button and entered the elevator. On 7/21/20 at 12:03PM V6, CNA, observed on the second floor passing meal trays. V6 delivered meal tray to R8's room, wearing a blue disposable gown. R8's door had an isolation sign on the door. While in the room, V6 touched the tray table as she repositioned it for the resident, a high touch surface. She placed the meal tray on the tray table. She then unrolled the silverware and removed plastic cover from the plate. V6 exited R8's room and removed the disposable gown at the nurse's station and did not perform hand hygiene. The room door was open and V6 could be seen. V6 did not perform hand hygiene while in R8's room. Next, at approximately 12:06pm, V6 observed entering R9's room without performing hand before entering. There was an isolation sign on R9's door. A hand gel station was located outside of R9's room door. On 7/21/20 at 12:08PM V11, CNA, said she should always hand wash or use hand gel between all residents or rooms. V11 said after removing personal protection equipment, including gowns, she should wash her hands or use hand sanitizer. On 7/21/20 at 12:10PM V2, Director of Nursing, said the expectation is that staff wash hands or use hand gel before entering a resident room. V2 said the staff has been in serviced on hand washing and infection control. V2 said hand washing is part of infection control and prevents the spread of infections. Facility training transcript dated 7/22/20 for the Infection Control and Prevention course denotes V6 completed the course on 05/29/20; V10 completed the course on 05/25/20; and V11 completed the course on 06/01/20. Facility's Hand Washing Policy dated 01/2017 denotes this facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of health care associated infections. All personnel shall follow the hand washing / hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.

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