STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145235	A. BUILDING _____ B. WING _____	**05/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEFRONT NURSING & REHAB CTR	**7618 NORTH SHERIDAN ROAD CHICAGO, IL 60626**

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.** Based on observations, interviews, and record reviews, the facility failed to follow its COVID -19 guidelines by not ensurirng residents are wearing a universal mask, group dining without maintaining social distance, not having hand sanitizer disposal in proper working condition and not ensuring a reliable, working temperature scan was used to obtain temperatures on residents, staff and visitors before entering the facility. These failures has the potential to affect all 90 residents residing in the facility and all staff working in the facility. Findings include: On 5/28/20 at 11:20 AM, observed hand sanitizer disposal on third-floor nurse's station hard to operate and hand sanitizer solution nearly empty. V8 (housekeeping staff) stated, I will report it to my boss to replace it. On 5/28/20 at 11:00 observed R8 and R10 walking in the hallway without wearing a mask. On 5/28/20 at noon, observed R9 and R11 walking in the hallway frequently without wearing masks. V9 (licensed practical nurse) stated, These residents need to be reinforced frequently to wear masks. I will tell them to wear a mask. Observed R8 and R10 entering into their room to get their mask after V9 instructed them to wear their mask. On 5/28/20 at 1:10 PM, V2 (Director of Nursing) stated, Residents are supposed to wear a face mask when they come out of their room. Facility presented COVID 19 guidelines and emergency preparedness plan dated on 5/8/20 documents: Universal masking will be done to comply with the CDC and regulatory department's recommendation to prevent the potential spread of COVID 19. On 5/28/2020 at 11:55 AM R4, R5 and R6 were siting in the first floor Dining Room. Two square 42 inch tables were pushed together to make one large table, 42 inches by 84 inches. R4 was sitting at one end of the table, R6 was sitting at the middle of the table, approximately 36 inches from R4. R7 was sitting at the far end of the table approximately 48 inches from R6. R5, R6 and R7 did not have masks on, they were waiting to be served lunch. V7 CNA (Certified Nursing Assistant) and V4 LPN (Licensed Practical Nurse) served lunch to R5, R6 and R7. No feeding assistance was given to R5, R6 or R7. The Dining Room is next to the PUI (Persons Under Investigation for COVID 19) unit. On 5/28/2020 at 12:00PM V7 stated, I am aware they should be six feet apart, and they are not. V4 stated, They (residents) are less than six feet apart. Because of COVID 19 ,droplets could travel, very dangerous, very contagious. I will move the tables apart or add another table. On 5/28/2020 at 1:00 PM V1 Administrator stated, The residents have the right to eat together, but they should be six feet apart for social distancing. The facility policy titled, COVID 19 Guidelines and Emergency Preparedness Plan, revives 5/8/2020 documents; Group dining and group activities will be canceled to comply with social distancing. Surveyor:(NAME)Winkfield On 5/28/20 at approximately 11:20am, V10(Activity Aide) and V11(Security Guard) were seated at the front enterance desk monitoring temps with a scan meter on all employees, residents and visitors. Writer's temperature was taken at least six times and temp scan did not work. Temperatures on scan read: 94.3, 93.5, 95.0, 95.5 degrees Fahrenheit. E1(Administrator) whom was present near the front desk said to V(11), What should the average person's temperature be? V11 stated, A person's temperature should be at least 96.0 degrees. On 5/28/20 at approximately 12:00noon, as writer proceeded to exit the building, V(10) performed temperature check at the front desk with the same thermometer scan. V10, again, attempted to take temperature multiple times and the temperature readings were sporadic, ranging from 93.5 to 95.5 degrees F. V11 requested to operate temperature scan but it did not work. At 12:10pm V2(DON) said to V10 and V11, It's not working. And agreed that the Temp scan was not reliable. At this time V1 came to the front desk to observe what was going on. V1 said, We will take care of it and replace it with a new one. COVID 19 guidelines and emergency preparedness plan dated 5/8/20 documents: Monitoring of resident's fever and/or new cough, sore throat, shortness of breath, chills, muscle aches, headache, or loss of taste or smell will be done a least every shift and recorded. Once there is a positive COVID-19 case in the facility, the monitoring for resident's fever and/or new cough, sore throat, or shortness of breath will be done every 4 hours. Staff's temperature will be taken before the start of work as described in screening above. Additionallly, staffs temperature may be taken again before the end of the shift.

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.