STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145885	A. BUILDING _____ B. WING _____	**06/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAYFIELD HEALTH CENTER	**5905 WEST WASHINGTON CHICAGO, IL 60644**

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 -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview and record review the facility failed to ensure that R1's IV (Intravenous) tubing was capped while not in use, failed to follow droplet precautions, failed to ensure that staff perform hand hygiene while serving food/drinks, and failed to ensure that staff were properly trained on infection prevention in an effort to prevent the spread of infectious microorganisms, including COVID 19. These failures have the potential to affect 107 residents. Findings include; The 6/1/20 census was 107. On 6/1/20 at 9:50am, surveyor inquired why visitors are allowed to touch the infection control (Covid 19) screening forms and pen (atop of the reception desk) V1 (Administrator) stated That's what we were told to do. The (6/1/20) 3rd floor roster includes blue zone (quarantined residents who transferred to the facility) and grey zone (convalescent Covid + residents). On 6/1/20 at 10:48am, V3 (Licensed Practical Nurse) affirmed that she was assigned to the 3rd floor and stated The majority on this side are Covid positive. Surveyor inquired what PPE (Personal Protective Equipment) was required for Covid 19 (negative) residents on the unit V3 stated We use standard precautions. Surveyor inquired what PPE is required for standard precautions V3 responded You don't even need PPE if they're non-Covid. The (6/1/20) 4th floor roster affirms R1 and R2 are positive for Covid 19. On 6/1/20 at 11:22am, R1 was lying in bed. A sign was posted on R1's door which states contact/droplet precautions, keep door closed however her door was wide open. Surveyor inquired what type of isolation R1 was currently on V8 (Agency Certified Nursing Assistant) responded Droplet. Surveyor inquired what PPE is required for droplet precautions V8 stated Whatever is in the containers, I'm guessing. R1's IV (Intravenous) medication tubing (dangling from the pole) was not capped. V8 affirmed [MEDICATION NAME] 2 grams was hanging from R1's IV pole, surveyor inquired if the attached tubing was capped V8 stated No. On 6/1/20 at 11:44am, R2 was lying in bed. A sign was posted on R2's door which states contact/droplet precautions, keep door closed however her door was wide open. Surveyor inquired if R2's door should be closed V9 (Registered Nurse) affirmed her door was open and stated She didn't close . well actually for the patients we need to know what's going on in the room. On 6/1/20 at 12:21pm, V12 (Certified Nursing Assistant) brought a lunch tray into room [ROOM NUMBER] and touched a wheelchair handlebar, she did not perform hand hygiene. She then brought a lunch tray to room [ROOM NUMBER], touched the door handle to enter, touched the bed controller, and touched the door handle to exit, she did not perform hand hygiene. She subsequently touched prepared drink cups, surveyor inquired about hand hygiene V12 stated We do it every 2-3 trays. On 6/1/20 at 12:38pm, surveyor inquired about education provided to staff for (Covid 19) infection prevention V1 stated The previous DON (Director of Nursing) educated staff at the beginning of April. It wasn't documented, she just was telling everybody about infection control. We didn't have anybody signing off on it, she just did it verbally. V23 (Marketing Director) affirmed We didn't document it, this was all being done verbally. Surveyor responded the in-service was not documented? V23 stated Correct. On 6/1/20 at approximately 6:45pm, surveyor received a (3/26/20) in-service attendance sheet titled All IDPH & facility policies regarding covid 19 no additional in-services were received during this survey. On 6/1/20 at 1:18pm, surveyor inquired if residents on droplet precautions should have their room doors closed V14 (Consultant) stated The doors are supposed to be closed. The Coronavirus (Covid 19) Policy (revised 3/20/20) includes; transmission: touching object or surface with [MEDICAL CONDITION] on it, then touching your mouth, nose or eyes before washing your hands. Use standard precautions for care with residents with undiagnosed respiratory infections. Post signs throughout the building describing ways to prevent the spread of germs. Encourage staff hand hygiene according to CDC (Centers for Disease Control) including before and after resident contact, after contaminated surface and equipment contact. The (undated) policy titled Care of Resident with Confirmed or Suspected Case of Covid-19 states residents with suspected or confirmed Covid-19 will have the door in their room kept closed at all times. The (6/1/20) 2nd floor roster affirms residents in rooms [ROOM NUMBER] are Covid 19 positive. On 06/01/2020 at 11:15am observed rooms 204, 208 and 210 with the doors open. Asked V19 (Registered nurse) if their doors should be open she stated no, but the residents won't keep them closed. The (6/1/20) 4th floor roster affirms residents in rooms 401, 402, 403, 405, 408, and 411 are Covid 19 positive. On 06/01/2020 at approximately 11:37am observed doors to rooms 401, 402, 403, 405, 408, 411 open. On 06/01/2020 at 11:45am asked V2 (Assistant Director of Nursing) should their doors be closed, she stated yes.

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.