

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 145999	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2020
NAME OF PROVIDER OF SUPPLIER GROSSE POINTE MANOR		STREET ADDRESS, CITY, STATE, ZIP 6601 WEST TOUHY AVENUE NILES, IL 60714	
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	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on observation, interview, and record review, the facility failed to follow their policy for properly containing the spread of COVID-19 by not wearing masks correctly while in the facility and providing resident care. This failure has the potential to affect all 63 residents currently in the facility. Findings include: 7/15/20 at 10:15 AM V3 (RN) was observed walking in and out of resident rooms and down the corridor with her mask worn below her nose and covering only her mouth. As she approached the surveyor, V3 adjusted her mask over her nose. At 10:20 AM, V4 (LPN-Licensed Practical Nurse) was sitting behind the nurses station with her mask worn under her nose but did not cover it. Surveyor asked V4 questions pertaining to residents in her care while V4 continued to wear her mask under her nose. At 11:35 AM, V4 was observed walking on the resident floor corridor and went back behind the nurses station and was again without her mask covering her nose. V2 (Director of Nurses) approached V4 and motioned to her to cover her nose with her mask. V3 and V4 were asked about PPE's (Personal Protective Equipment) with both affirming that masks should be worn over the nose and mouth to help prevent the spread of infections such as the coronavirus. At 11:45 AM, V5 was observed in the dining room assisting residents before lunch. R1 was seated back in her recliner and V5 had her mask lowered down to her neck not covering either her nose or mouth. V5 spoke in a high volume directly over R1 as she tried to communicate with R1 who only spoke Spanish. V5 stated, I was trying to talk to (R1) and I should have been wearing my mask. I know very little Spanish and R1 is confused so I was trying to calm her down. Surveyor asked if she regularly worked with R1, V5 stated, Yes but I work all over (the facility). V2 (DON) was asked by surveyor if R1 was considered high risk for COVID infection and V2 stated, Well all our residents are at risk. Surveyor asked whether R1 was positive for COVID-19, V2 stated, (R1) was positive when she was tested for Covid-19 but she is no longer positive for the disease. Records show R1 with a recent history of positive COVID-19 infection in June of 2020 and [DIAGNOSES REDACTED]. Facility policy dated 3/9/20 titled, Covid-19 Policy & Procedure states, Purpose: To reduce the risk of transmission of the Coronavirus Disease in this healthcare setting. Responsibility: Physicians, Physician assistants, nurse practitioners, facility staff, students and volunteers will assess situations and implement Standard and Transmission-Based Precautions to break the chain of infections. Policy: The facility will conduct education, surveillance and infection control and prevention strategies to reduce the risk of transmission of Covid-19. Ensure adherence to standard, contact and droplet precautions. a.) Perform hygiene before and after all resident contact and before donning and upon removal of PPE, including gloves. b.) Use personal protective equipment appropriately. Don mask: ensure bands are secured behind ears and fit snug to cover nose and below chin.</p>		
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.