

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>145852</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>06/09/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>BROOKDALE PROSPECT HEIGHTS</b>		STREET ADDRESS, CITY, STATE, ZIP <b>700 EAST EUCLID AVENUE PROSPECT HEIGHTS, IL 60070</b>	
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  <b>Level of harm - Minimal harm or potential for actual harm</b>  <b>Residents Affected - Many</b>	<p><b>Provide and implement an infection prevention and control program.</b></p> <p>Based on observation, interview, and record review, the facility failed to properly contain COVID-19 by not following their infection prevention and surveillance policy and procedures. This failure affected two (R2 and R3) of four residents reviewed for infection control and has the potential to affect all 19 residents currently on the unit. Findings include: 6/8/20 at 11:50 AM, V3 (Assistant Director of Nurses) stated, I along with my DON (V2) are the infection control designees. We have two residents currently on isolation for active infections and two that are quarantined for 14 days because they came from the hospital. V3 also stated that an isolation carts are placed outside of these rooms and there are signs on the door. The carts have personal protective equipment (PPE) such as gowns, gloves, masks and staff need to put on PPE's prior to entering the room. 6/8/20 at 12:05 PM, observed rooms for R1 and R4 with isolation carts and signage on doors for anyone entering these rooms to see the nurse prior to entering; R1 and R4 have active infections. R2 and R3's rooms had no isolation carts nor signage to indicate that either residents were quarantined as stated by V3 to prevent potential spread of any infections. 6/8/20 at 12:10 PM, V4 (Registered Nurse), stated that she has one person on her side on quarantine and another on the other side but that resident belongs to the other nurse. When asked why there were no isolation carts or signage to designate residents on quarantine, V4 stated that they just use universal precautions for all residents. 6/8/20 at 12:10 PM, V1 (Administrator) stated, We'll start placing signage on our doors to show which residents are quarantined. 6/8/20 at 12:15 PM, V2 (Director of Nurses) stated, I agree that the residents that are quarantined are adhering to staying in their rooms but I see that staff should treat quarantined residents similar to isolation and we should be placing signs on our doors for these residents. Policy dated 4/2020 titled, Communicable Disease Control includes: Residents suspected of contracting a potentially communicable or infectious disease, may remain in the community with appropriate infection control measures unless directed otherwise by the local or state departments of health/public health/human services. Standard Precautions will be exercised regarding resident care, including the handling of any personal resident items. If a serious outbreak of a highly contagious disease occurs within the community, strict adherence to standard precautions, use of personal protective equipment (gloves, gowns, masks, etc.) should be used and implemented according to the most current CDC and Prevention recommendations. The resident will be restricted to his/her room until a further assessment is completed by the Nurse and/or resident's physician. The community will provide supportive care for the residents such as meals, fluids, and facilitate transportation to the hospital if medical care is needed. Signage, indicating for visitors to stop and check with the nurse or care associate before entering, will be posted on the residents apartment or room door. Upon determination of infectious disease, the resident will remain restricted to his/her room and results of the assessment will be reported to primary care physician, responsible part, appropriate agencies per state regulations.</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.