

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 145626	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/28/2020
NAME OF PROVIDER OF SUPPLIER GENERATIONS OAKTON PAVILLION		STREET ADDRESS, CITY, STATE, ZIP 1660 OAKTON PLACE DES PLAINES, IL 60018	
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	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that staff/visitors wear face mask as recommended, failed to perform hand hygiene after resident contact, and failed to socially distance residents to prevent and/or contain the possible spread of infectious microorganisms, including COVID 19. These failures affected all 19 residents on the first floor and all 45 residents residing on the 3rd floor. Findings include, On 5/27/20 at 9:36 am, V3 (Physician Assistant) was observed sitting at the first floor nurses station (Covid-19 Unit) and not wearing a face mask. On 5/27/20 at 10:46 am, V4 (Certified Nursing Assistant) was observed leaving R3's room; however she did not sanitize her hands. On 5/27/20 at 12:37 am, V2 stated the facility has universal mask policy for staff and visitors; it has to be worn at all times and it has to completely cover the nose and mouth. Facility policy Universal Mask Policy documents in part: All staff must wear procedure/surgical mask while present at the Facility. Facility Policy Isolation Precautions documents in part: A. Hand hygiene must be performed immediately after removing and disposing of PPE (Personal Protective Equipment), between resident contact, and when otherwise indicated to prevent contamination. Facility policy COVID-19 Visitor Restriction documents in part: b. Essential visitors MUST i. Perform hand hygiene ii. Use Personal Protective Equipment (PPE);</p> <p>On 5/27/2020 at 10:16am in 3rd floor dining room, V5, Activity Aide was leading group in activity. R5, R6, R7, R8, R9, R11 were sitting in wheelchairs in a semi-circle, no social distancing (less than 6 feet apart), and no masks on residents engaging in group exercises. R10 was sitting in wheelchair coughing, but not covering mouth. On 5/27/2020 at 11:34am V5 was talking to R5 with close face to face contact, while wearing mask below chin, not social distancing. V5 stated, I did not have any training on how to wear mask, they just gave me a mask and I throw it on. I am suppose to wear mask at all times. On 5/27/2020 at 11:49am, R12 was observed getting coffee from coffee container, touching coffee container and condiments, without doing hand hygiene. On 5/27/2020 at 12:07pm, V6, Certified Nursing Assistant, was observed touching rim of multiple glasses while serving drinks to residents. V6 stopped and opened window blinds, then returned to passing out beverages without doing any hand hygiene.</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.