STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145601	A. BUILDING _____ B. WING _____	**10/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVISTON COUNTRYSIDE MANOR	**450 WEST 1ST STREET AVISTON, IL 62216**

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 -** Few	**Provide and implement an infection prevention and control program.** Based on interview and record review, the facility failed to operationalize their Policy regarding guidelines to reduce the risk and prevent the spread of infections for the spread of COVID-19 in the facility for 2 of 2 residents (R1, R5) reviewed for COVID-19 Infection Prevention and screening in a sample of 7. Findings include: 1. On 10/19/20 at 12:40 PM, V6, Licensed Practical Nurse, assisted V5, Certified Nurse Aide with serving residents lunch meals. V5, wearing personal protective equipment, (PPE)- (gloves), opened R1's door handle, entered room, laid the lunch meal disposable plates on R1's bedside table, then moved R1's bedside table in front of R1 to provide meal set-up. V5 exited R1's room with same gloves, applied alcohol based hand sanitizer on gloved hands, then approached V6 to receive a lunch meal plate, V5 with same gloved hands, used gloved hands to open R4's closed door handle and delivered R4's lunch meal. 2. On 10/19/20 at 12:50 PM, V5 wearing the same PPE gloves, entered a COVID positive hall. V5, using the same personal protective gloves, opened R5's door touching the door handle, entered R5's room, placed R5's lunch meal on bedside table, V5 then went to the foot of R5's bed to raise R5's head of bed up, then positioned R5's bedside table in front of R5 for meal set-up, using the same gloves, V5 then exited R5's room, applied hand sanitizer on the gloves, and received an additional meal tray, from V6 and entered R6 and R7's room, using the same personal protective gloves. On 10/19/20 at 12:20 PM, V5, stated you are to wear the full PPE equipment, gown, N95 mask, face shield or protective eyewear, gloves for all the COVID negative residents, and gloves are changed if providing direct care or visible soiled. On 10/19/20 at 1:00 PM, V1, Acting Administrator stated, she expects staff to dispose of gloves if direct resident contact is made or visible soiled. The Facility's Policy, dated 8/31/20, entitled, COVID-19 Preparedness, documented Hand hygiene using Alcohol Based Hand Sanitizer before and after all patient contact and contact with infectious material. The Facility's Policy, undated, entitled, Hand Hygiene, documented, hand hygiene before having contact with residents food, Wear gloves if touching a residents food. Remove gloves promptly after touching environmental surfaces.

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.