STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145367	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE HEALTH-GILLESPIE	**7588 STAUNTON ROAD GILLESPIE, IL 62033**

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 observation, interview and record review, the facility failed to prevent the spread of infections, such as COVID-19 as evidenced by failure to adhere to infection control practices, related to staff failure to assist residents with donning face masks and keeping the doors closed to residents who were COVID19 positive. These practices had the potential to affect all 12 residents who reside on the COVID-19 designated unit. Findings include: 1. On 09/02/2020 from the hours of 8:00 am to 9:30 am, R1 was sitting outside of her room, in the hallway without a facemask. V3, Certified Nurse Assistant, (CNA), and V2, Registered Nurse/ Director of Nurses, (RN/DON), passed by R1 several times while she was sitting in the hallway, without assisting or reminding R1 to put a facemask on when outside of her room. R1's Laboratory result, dated 08/25/2020, documents that R1 was positive for COVID19. R1's Physician Order, dated 08/26/2020, documents, Admit to Medicare A-Skilled Services for daily Skilled Nursing Assessment and strict isolation, (due to positive) Covid-19. R1's Care Plan, dated 09/02/2020, documents, Monitor and ensure that I have my mask on when I am out of my room. Verbal cue and assist me to put my mask on when I come out of my room. 2. On 09/02/2020, from 9:00 am to 9:15 am, R3 wheeled out into the hallway and he was asking for help. R3 did not have a face mask on at that time. V3, CNA and V2, RN/DON were both in the hallway passing breakfast trays but, neither one of them address R3 not having a face mask on nor did they assist him to don a face mask. R3's Laboratory result, dated 08/25/2020, documents that R3 was positive for COVID-19. R3's Physician Order, dated 08/26/2020, documents, Admit to Medicare A-Skilled Services for daily Skilled Nursing Assessment and strict isolation, (due to positive) Covid-19. R3's Care Plan, dated 09/02/2020, documents, Monitor and ensure I am wearing a mask when I come out of my room. Verbal cue and assist me to put/keep mask on when out of room. On 09/02/2020 at 8:10 am, V3, CNA, stated that R1 does not like to wear a facemask that is why she don't wear one. V3 continued to state, that it is very hard to keep facemask on the residents when they wander out of their rooms. 3. On 09/02/2020 between the hours of 8:00 am to 9:30 am, R1's, R2's, R3's, R5's, R6's, R7's, R8's, R9's, R10's, R11's and R12's doors were all open to the hallway. On 09/02/2020 at 8:10 am, V3, CNA stated, that R8 wanders and that is why her door stays open but, couldn't say why or if all the other doors should be open. On 09/03/2020 at 3:00 pm, V1, Administrator, stated, that the reason why the doors were left open, is because we need to keep an eye on them because, they are high fall risk and we have no way of monitoring them, otherwise the doors would be closed. V1 continued, to state that she would expect the staff to monitor and assist residents to wear their face mask when coming out of their rooms. The facility's policy, COVID19 Testing and Response Plan, dated 08/13/2020, documents, C. Residents with confirmed COVID19 or displaying respiratory symptoms should receive all services in room with door closed if safety permits, (meals, therapy, activities, and personal hygiene, etc.) It continues, E. Encourage and assist all residents to wear a face covering for source control whenever they leave their room or are around others, including whenever they leave the facility for essential medical appointments.

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.