STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145406	A. BUILDING _____ B. WING _____	**06/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RANDOLPH COUNTY CARE CENTER	**312 WEST BELMONT SPARTA, IL 62286**

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	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review the facility failed to: 1) Follow recommended procedures for screening staff and visitors for signs and symptoms of COVID-19 upon entry to the facility. 2) Follow current recommended standards of practice for effective facility disinfection. This has the potential to affect all 47 residents residing in the facility. Finding include: On 06/2/20 at 08:30 AM, V1 (Administrator) stated there are 47 residents that reside at the facility. The facility has dedicated the 200 South Hall for COVID-19 residents. V1 stated that currently, 0 residents present in the facility are positive for COVID-19. V1 stated 1 resident (R2), previously tested positive and resided on the COVID-19 unit during his quarantine period. V1 states R2 is currently in the hospital for a non COVID-19 related medical procedure, and despite 2 negative COVID-19 test results completed at the facility, they were notified R2 tested positive for COVID-19 at the hospital upon his arrival. 1) On 6/2/20 at 8:25AM, signage was observed on the front door of the facility noting visitor restrictions. Upon entering the lobby area of the facility, no staff were observed providing screening procedures, nor were instructions visible directing visitors of the need for screening or procedures. At this time the facility/resident hallway is able to be entered at will with no screening directive posted or screening personnel present to prohibit entrance. Surveyors entered administrative office(s) area in which V14 (Medical Secretary) was observed at her desk. After introducing ourselves and explaining our business at the facility, we were escorted to the conference room. After introduction with V1 and explanation of the survey nature, V1 asked if we had been screened, in which we responded no. V1 instructed V14 to take us back out front for screening. V14 escorted us back to the lobby entrance of the facility. A table with a baggie of alcohol wipes, temporal thermometers, papers, hand sanitizer, and a folder were observed lying on a table. V14 asked each surveyor their name and took our temperatures. V14 was observed writing our names along with our temperature on a document titled, Covid-19: Screening Checklist-for visitors and staff. Those forms were placed inside of the folder. Surveyors were asked to apply alcohol-based hand sanitizer. Asking our names, applying hand sanitizer, and a temperature check concluded the visitor screening process. V14 was asked if she provides the screening for visitors and staff? V14 stated if she needed to, but the facility does not have visitors at this time and staff screen themselves at the beginning of their shift. On 6/2/20 at 8:30 AM, V1 states all staff enter the front door of the facility and screen themselves which includes checking their own temperature and completing a screening form, which they then leave in an envelope on the screening table. V1 states staff who are experiencing illness, or a temperature are asked to leave. On 6/2/20 at 09:30 AM, When asked how staff are screened V2 (Registered Nurse) states, We come in and take our own temperature. V2 describes all staff using the front door and temperature supplies being left on a table there for their use. V2 states they write their name and temperature on a form, also left on the temperature table for them and put them in a folder on the table once complete. V2 was asked if there was any other component to the staff screening process in which she replied, there are some questions on that form, I think we just answer the first one or so though. V2 states if staff have a fever or feel ill, they are to report their symptoms and go home. On 6/2/20 at 9:40 AM, When asked how staff are screened V3 (Licensed Practical Nurse) states, We take our temp (temperature) when we get here. V3 states staff all enter the front door where they take their temperature and write it on a form with their name and leave it in a folder. V3 states staff are responsible for taking their own temperature. V3 states if staff have a temperature or signs/symptoms of illness, they are to go home. On 6/2/20 at 9:45 AM, V10 (Certified Nurse Assistant) (CNA) and V13 (CNA) stated that they do their own temperature screenings when they arrive to work. Both V10 and V13 state that temperature is the only required thing to do, and they just write it down on the paper and stick it in the folder at the table where the thermometers are. The Facility Policy titled Infection Control COVID 19 with a revision date of 3/20/20 states: Preventing the introduction of COVID19 into the facility Number 8.) Monitoring employees for fever or respiratory symptoms, such as cough, or shortness of breath at the beginning of their shift take temperature at the beginning of shift. Monitor for cough or shortness of breath. In a document provided by the facility titled COVID-19 Long-Term Care Facility Guidance, dated April 2, 2020 states: 3. Long-term care facilities should immediately implement symptom screening for all. In accordance with previous CMS guidance, every individual regardless of reason entering a long-term care facility (includes residents, staff, visitors, outside healthcare workers, vendors, etc.) should be asked about COVID-19 symptoms and they must also have their temperature checked 2) On 6/2/20 at 8:35AM, V5 (Housekeeping) stated that there is no set schedule for cleaning high touch surface areas. It happens once a shift, and he typically does it towards the end of shift. V5 cannot think of any extra training or in-services he has had regarding sanitizing through this pandemic. On 6/2/20 at 9:01 AM, V9 (Housekeeping Supervisor) stated that there is not a set schedule for wiping down high touch surface areas. The staff just do it once a shift. V9 went on to state that they use an ammonia product or bleach tablets. V9 explained that the bleach tablets are dissolved in a spray bottle with water, and that the ammonia product is mixed with water as well. V9 did not give specific amounts of ammonia to water ratio, she stated a half a lid full or so goes in the spray bottle and it's ready to go. On 6/2/20 at 9:50 AM, V11 (Housekeeping) stated that she has not had any special COVID training on disinfecting. The product used is an ammonia formula to disinfectant surfaces and the floor like usual. There has not been any extra education, they just do their usual routine of cleaning. No schedule of regular cleaning of high touch surface areas have been made, she just does it once a shift. The Facility Policy titled Infection Control COVID 19 with a revision date of 3/20/20 states: Preventing the introduction of COVID19 into the facility Number 1.) A5: clean and disinfects the environment appropriately. Using a hospital grade disinfectant for frequent cleaning of high touch surface areas and shared resident equipment.

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.