STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E812	A. BUILDING _____ B. WING _____	**09/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MOUNT VERNON HEALTH CARE CENTER	**#5 DOCTORS PARK MOUNT VERNON, IL 62864**

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 -** Immediate jeopardy **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection control procedures to prevent the spread of Covid-19 infection by failing to: 1) Immediately isolate and identify residents (R2, R3, R4, R7) displaying the symptoms of Covid-19 infection; 2) Monitor vital signs and provide timely medical treatment for 7 Covid-19 infected residents (R1, R2, R3, R4, R5, R6, R7) per Covid-19 policy for which 4 residents became gravely ill and subsequently expired; 3) Implement immediate quarantine protocols for a resident (R8) upon readmission to the facility following a hospitalization ; 4) Don and doff PPE (Personal Protective Equipment) according to policy; 5) Perform staff Covid-19 screenings prior to entrance into the facility; and 6) Restrict access to the Covid-19 Unit from confused, ambulatory, non-Covid-19 positive residents. This failure has the potential to affect all 55 residents living in the facility. This failure resulted in an Immediate Jeopardy on [DATE] when R4 was noted to be experiencing Covid-19 related symptoms such as uncontrollable coughing with a temperature of 99 degrees Fahrenheit and not being identified as being Covid-19 related. As R4's condition continued to deteriorate with O2 stat dropping to 66% percent with no medical intervention obtained, R4 expired on [DATE], with one of the causes of death being novel corona Covid-19. V1, Administrator and V2, Interim Director of Nurses were notified of the Immediate Jeopardy on [DATE] at 2:18pm. On [DATE] the surveyor confirmed by observations, record review and interview that the Immediate Jeopardy was removed on [DATE], but non-compliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of in service training. Findings include: 1. R4's closed record review documents the following in part - A Nursing Note dated [DATE] at 3:00am documents the following - Up to bathroom, coughing uncontrollably, lung sounds are clear but does have raspy sound on inhalation and exhalation. [MEDICATION NAME] (cough medication) 10 milligrams given by mouth and tolerated well. [DATE] at 3:30am: Cough subsided and (R4 is) resting well at this time. Complains of being cold. Blanket placed on 2 other blankets. Two additional nursing notes this day document, Covid monitoring continues, with vitals documented on the 2pm to 10pm shift as being within normal limits. R4's Nursing Note dated [DATE] on 10P-6A shift, by V19, LPN, documents an elevated temperature of 99 degrees Fahrenheit, and Increased monitoring for Covid-19, no signs or symptoms at this time. Will monitor. At 11:50 PM on this same date, same LPN documents, PRN (as needed) [MEDICATION NAME] given related to cough. Will monitor. Nursing notes dated [DATE] and [DATE] by V17 (RN) document, Covid monitoring continues. [MEDICATION NAME] given. No signs or symptoms of Covid. Will monitor. No documentation of R4's vitals are noted on these dates. R4's Nursing Note dated [DATE] at 5:15 PM with no nursing signature documents the following - Resident lying in bed. Pulse oxygenation 66% (percent) oxygen applied at 3 liters per nasal cannula, pulse 122, blood pressure ,[DATE]. There is no documentation of follow-up vital signs taken or any other notes documented on this date. R4's Nursing Note dated [DATE] at 11:00 AM by V17 documents at 11:00 AM vital signs were taken and O2 sats were 54% on room air, and, Oxygen applied at 5 liters per nasal cannula Call (at) (2:00 PM) to V18 (Physician) - new order to send to emergency room for evaluation and treatment. (Local ambulance service) called and (R4 was sent to)(a local hospital). 6:30 PM note documents V17 spoke to an RN at the transferring hospital and R4 had been admitted with [DIAGNOSES REDACTED]. R4's Nursing Note dated [DATE] documents Increased monitoring for signs and symptoms of Covid. No signs or symptoms of Covid, will continue to monitor. According to previous Nursing Notes, R4 was in the hospital at this time. R4's Nursing Note dated [DATE] by V1 documents the facility was notified on that date that R4 had passed away at the hospital. R4's Nursing Note dated [DATE] documented, Positive Covid-19 test result received. R4's Certificate of Death Worksheet dated [DATE] documents, Cause of Death: a) acute hypoxic [MEDICAL CONDITION], b) bilateral pneumonia; c) novel corona covid-19 virus infection. On [DATE] at 10:40am, V1 stated she worked the [DATE] midnight shift, and R4 slept the rest of the night after cough medicine was given. V1 stated she would not consider R4's cough or a low-grade temp of 99 degrees Fahrenheit to be a symptom of Covid. The cough was not unusual for her. I do see a problem with waiting 3 hours in calling the doctor when her oxygen was low. V1 stated, Any time you have a low O2 sat and apply oxygen, you should notify the doctor and family. Any time a prn (as needed) treatment is applied we do follow-ups. On [DATE] at 4:20 pm, V1 stated R4 remained in the same room upon admission. V1 stated the reason R4 was tested for Covid-19 on [DATE] was because that's when the facility decided to test the whole facility because they had wanted to begin outside visits. 2. R5's Nurses Notes document that from [DATE] through [DATE], there were zero days in which the vital signs were checked every four hours, with no vital signs documented from [DATE] through [DATE] and none on [DATE]. R5's Nurses Notes for [DATE] documented that vital signs were checked at 12:30am, 4:30am, and 9:00pm. The 9:00pm note documented, Poor appetite, diminished lung sounds on both sides. R5's [DATE] 7:30pm Nurses Note documented, Called to patient room, upon assessment noted patient without pulse and respirations. This nurse initiated CPR (Cardiopulmonary Resuscitation) while another staff member called EMS (Emergency Management Services).On [DATE] 7:45pm Nurses Note documented, EMS arrived, verified patients (deceased) status, at this time called Coroner. A Death Certificate dated [DATE] documented, Cause of death: Part 1: A) Inanition. B) Protein/Calorie Malnutrition. C) Stopped Eating and Drinking. Part 2: Covid-19 Positive Asymptomatic. On [DATE] at 9:25am, V2 stated the [DATE] 9pm note was in error and should have been recorded as 9:00am, not pm. V2 stated staff should have notified R5's medical provider of the change in status at 9:00am, although this was not done. V2 stated prior to having contracted Covid, R5 had begun to decompensate and had begun to refuse food. V2 stated R5 was receiving various nutritional interventions for this issue. 3. R6's record showed a gap in Nurses Notes documentation from [DATE] at 5:30pm until [DATE] at 12:12pm. Repeated requests to the facility to provide this documentation failed to produce it. There is therefore no documentation that vital signs were monitored at any time during that period. R6's medical record documented an [DATE] Lab Result, Positive for [DIAGNOSES REDACTED]-CO-V-2 (Covid-19). A Nurses Note dated [DATE] at 12:12pm documented, Resident moved from Covid Unit to recovery room. No signs or symptoms of Covid. The next entry is [DATE] at 9:15pm documenting, Resident is deceased . There was no documentation in the chart between 12:12pm to 9:15pm, including any evidence of vital sign monitoring. R6's Death Certificate dated [DATE] documented, Cause of Death: A) Hypertensive [MEDICAL CONDITION]. B) Dementia. On [DATE] at 9:25am, V2 stated he did not remember anything unusual happening with R6 the day she passed away. V2 stated he had been surprised to hear R6 had passed away. 4. R7's closed record review documents positive lab result for Covid-19 dated [DATE]. Facility Resident Infection Control Log documents onset date of [DATE]. A nursing note dated [DATE] documents increasing monitoring for s/s of Covid. No s/s of Covid. Will continue to monitor. R7's record does not contain any documentation from [DATE] through [DATE]. A hand written note on R7's August physician's orders [REDACTED]. R7's nursing note dated [DATE] documents, Drainage from eyes noted. Eyes washed. Nursing Notes dated [DATE] began documenting at 9:00 AM that R7 was Not demonstrating the ability to respond to stimuli, bilateral bronchi in lungs, no pedal pulses, skin cold to touch from toes to knees, labored respirations. Family called and hospice requested. A Nursing Note at 10:05 am (late entry) documents, Called to room due to (R7) having no pulse or respirations. Further Nurses Notes documentation on [DATE] indicated R7 passed away in the facility. On [DATE] at 10:30am, V1 stated she was attempting to locate R7's records that had been misplaced or were in boxes. She stated nothing was where it was supposed to be due to agency staff who had been called in to assist during Covid-19. R7's Certificate of

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.

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F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 1) Death Worksheet dated [DATE] documents R7's Cause of Death as a) Covid-19; b) dementia end stage. 5. R2's Face Sheet dated [DATE] documented R2 was residing on the facility's Long term Care Unit. A Nurses Note dated [DATE] at 10:15pm documents, No signs or symptoms of Covid at this time. A Nurses Note dated [DATE] at 10:30pm documented, Resident up ad-lib, ambulates per self. Complains of sore throat and cough at this time. Will continue to monitor. There was no accompanying documentation to indicate R2's medical provider had been contacted nor that R2 had been placed in isolation. R2's Nurses Note dated [DATE] at 3:30 AM documented, Cough, sore throat, complaining of sore throat badly. Doctor Communication sent: (New order received) for labs and chest x-ray. A Nurses Note dated [DATE] at 9:30pm documented, Received chest x-ray and labs CMP (Complete Metabolic Panel) and BMP (Basic Metabolic Panel). Called results to (Physician Assistant) with no new orders, just to let her know if any change in symptoms. Will continue to monitor. Again, there was no documentation to indicate R2 had been isolated from other residents. R2's Lab Report with a collection date of [DATE] and a final result date of [DATE] documented Covid Positive. A Nurses Note dated [DATE] at 2:00am documented, (Lab) Report came back positive for Covid-19. A Nurses Note dated [DATE] at 5:45am documented, Resident moved from negative Covid unit to Covid Unit. R2's Nurses Notes documented there were zero days between [DATE] through [DATE] in which the vital signs were monitored every four hours. Repeated requests to the facility to provide Nurses Notes documentation prior to [DATE]. No documentation was provided. On [DATE] at 9:25am, V2 acknowledged that when R2 developed a cough and sore throat, R2 should have been isolated and R2's Physician's Assistant contacted. V2 stated when R2's lab returned positive for Covid on ,[DATE] at 2am, R2 should have been immediately moved to the Covid unit. V2 stated R2 is ambulatory and confused, and while on the Covid Unit has ambulated from her room to the front entrance foyer to look out the front windows. V2 stated staff have to encourage her to stay in her room and remind her to wear a mask if she leaves the room. V2 acknowledged despite nursing staff repeatedly being told to monitor each resident's vitals every four hours, there are instances of it still not being done. 6. R3's medical record documents she currently resides in a room on the Covid-19 unit, having been moved to this location on [DATE] following a report by the lab that R3 tested positive for Covid-19. Prior to moving to the Covid-19 unit, R3's nursing notes include the following in part - [DATE] at 5:05 AM by V19 (LPN, Licensed Practical Nurse) - Vital signs documented with Oxygen saturation (O2 sat) at 90.1% (percent) on room air. No signs or symptoms of Covid. Will continue to monitor. [DATE] at 5:05 AM by V19 - 02 sats at 90.1% on room air. [DATE] at 4:30 PM by V20 (Registered Nurse) - O2 sats at 90% on room air. [DATE] at 10:00 AM by V20 - O2 sats at 90% on room air. There is no documentation of oxygen being applied, or of a follow-up O2 sat being checked on these dates. A Nursing Note dated [DATE] at 11:30 PM by V22 (LPN) documents, Notified by lab R3 is positive for Covid-19. A Nursing Note dated [DATE] at 4:50 AM by (illegible, unknown LPN) - (R3) was received into the Covid-19 Unit for isolation due to positive results. R3's record indicates there was a 5 hour and 20 minute delay in transferring to the Covid-19 unit after staff received notification from lab R3 tested positive. [DATE] at 4:50am was the final documentation in R3's record, with no indication R3's vital signs were being monitored every four hours. On [DATE] at 9:32am, V1 stated she would have expected the nurses to have applied oxygen, documented this, and rechecked her 02 sats, and would also have expected a call to R3's hospice team, doctor, and an update to R3's family. V1 stated she also could not read the name of the staff who authored the [DATE] 11:30pm Nursing Note, but she believes it to be an agency nurse. V1 stated she's not sure why there was a delay in R3 being moved because the Covid unit was ready. V1 stated she believed it may just look like there was a delay due to the time the agency nurse charted on [DATE]. 7. R1's Lab Result with a collection date of [DATE] and a final result dated [DATE] documented, Covid-19-Positive. Nurses Notes documented there were zero days between [DATE] and [DATE] in which the vital signs were monitored every four hours. Throughout the duration of the survey, repeated requests were made to the facility to provide Nurses Notes documentation prior to [DATE] for R1. No documentation was provided. On [DATE] at 8:20 AM, V1, Administrator, and V2 (Acting Director of Nursing - DON/Infection Control Preventionist - ICP) stated there are currently three residents housed on the facility's Covid Unit. V1 and V2 stated due to having current positive cases of Covid in the building, all residents in the facility are to have their vital signs checked at least every four hours during waking hours. 8. On [DATE] at 10:20 AM, V1 stated the facility had one resident (R8) on quarantine in his room due to a recent return from the hospital. On [DATE] at 11:42 AM, R8 was observed in his room dressed and up in wheelchair. At 11:44 AM, R8 was observed self-propelling his wheelchair out of his room and down to the nursing station where this surveyor stood. R8 told staff he wanted to lay down. Staff told R8 he was going to get lunch soon. When asked when R8 had returned from the hospital, V15 (LPN) stated she was not R8's nurse, but would go get him. At 11:46 AM, V16 (RN) introduced himself and stated he was R8's nurse. When asked if R8 had been out to the hospital and returned recently, V16 stated yes, he's been back 5 days. When asked if R8 was on any kind of quarantine, V16 stated he just learned today ([DATE]) from V2 that R8 was supposed to be on quarantine. V16 stated he has only worked at this facility for 5 days but had been taking care of R8 during that time. V16 stated he had just reviewed the policy and quarantine means they are to stay in their room. V16 further stated that R8 had been doing everything a resident not on quarantine would do with activities of daily living and going to the dining room. When asked if he would have expected to be notified upon R8's readmission to the facility he was to be quarantined for 14 days, V16 stated, I would expect to be notified that one of my residents was on quarantine. This is only my 5th day and I came from a facility that was very strict. A Covid-19 Assessment Sheet note dated [DATE] at 11:30 AM, V17, RN, documents R8 is Quarantined to room. Will continue to monitor. A Nursing Note section on the Covid-19 Assessment Sheet dated [DATE] at 6:30 PM documents R8 was Up to dining room in wheelchair, appetite good. On [DATE] at 8:20 AM, V2 stated he was notified by a second shift nurse on [DATE] that R8 had returned from the hospital and was being placed on quarantine in his room. V2 stated report is given between shifts and there is a resident status binder at the nursing station to refer to. When asked why staff would have stated they were not aware until [DATE] that R8 was on quarantine, V2 stated he didn't know. The facility map illustrates Covid + Red Zone rooms are mapped out. The rest of the facility is marked as Yellow Zone Recovery, which includes both the Alzheimer's and Long-Term Care unit. V1 and V2 explained the facility is basically split into three sections, the Covid positive rooms, the Alzheimer's/Covid recovery unit, and the Long-Term Care side. When asked how non covid related isolation needs are met, they stated there are currently no residents on isolation other than the 3 covid positive residents housed on the Covid Unit. When asked where they quarantine residents who are in and out of the facility for appointments or return from a hospital stay, they stated that resident is quarantined in their room for 14 days. 9. On [DATE] at 8:00 AM, the surveyors were met at the facility's main entrance by V3 (Unit Aide). V3 stated she was responsible for screening staff who utilize that entrance and are working on the facility's Covid-19 unit. V3 stated she would need to take the surveyors temperatures but would need to find a working thermometer. V3 stated the two staff working on the Covid-19 unit that day, V4 (Licensed Practical Nurse/LPN), and V23 (Certified Nursing Assistant/CNA), were agency staff who brought their own thermometer and took their own temperatures when they came in that day. While V3 completed the Covid-19 checklist questions with the surveyors and put the completed forms in a binder, the surveyor asked to see the screening documentation for V4 and V23. V3 was only able to produce a document for V23 from the binder and not V4. On [DATE] at 8:10 AM, V1 (Administrator) stated she screened herself when she came into the facility that morning. V1 stated she was not aware of anything in the regulations stating staff could not self-screen. V1 produced the screening form from her desk rather than from facility screening binder. V1 stated all staff are to be screened before coming into the facility before their shift, and again four hours into their shift. V1 stated V3 is stationed at the Covid-19 unit entrance this day, with V24 (Unit Aide) stationed at the main employee entrance by the time clock, and they are the staff members responsible for screening. On [DATE] at 8:15 AM, V4 (LPN) was working on the Covid-19 unit and stated she was screened by V3 this morning. When asked to see her thermometer, she pulled out a digital temple touch from her bag. When asked to take her temperature, V4 got a reading of 95 degrees Fahrenheit with three attempts. When asked where her screening paper was, she stated V3 had it. On [DATE] at 9:25am, V23 Unit Aid, stated she and her boyfriend V7, Dishwasher, came in at the same time that morning. V23 stated she performed V7's screening and V7 performed V23's screening. V23 stated it is the individual employees' responsibility to make sure they are screened prior to their shift and again four hours into the shift, which for most employees occurs at their break or lunch. V23 stated to keep track of who has been screened, she looks through the binder, and if there are any blank spaces and she knows the employee is there that day, she goes and finds the employee and screens them. V23 stated employees beginning their shift without being screened occurs on a regular basis. V23 stated an example of this is that when V23 came to work on [DATE], she noticed while looking through the screening binder that one of the dietary staff had not been screened, although V23 had seen the staff member in the kitchen. V23 stated she gets to work at 7:30am to 8:00am each morning, and V23 is not sure who is responsible for screening staff who come in before that time. On [DATE] at 11:20am, V12 (Housekeeping Supervisor/Certified Nursing Assistant(CNA)), was observed at the facility's main entrance/Covid Unit Entrance. V12 stated she was the staff member responsible for screening that day. V12 checked the

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) surveyor's temperature using a thermal scanning type thermometer. The surveyor's temperature registered 87 degrees Fahrenheit. V12 then started to take the other surveyor's temperature with the same device. When the surveyor questioned the validity of the result, V12 then rechecked the surveyor's temperature which then registered at 94.5 degrees Fahrenheit. When this result was again questioned, V12 acknowledged perhaps the thermometer was not working properly, but made no effort to obtain a different thermometer and recheck the result. V12 did not review the Covid Screening Checklist with the surveyors as V3 had done on [DATE]. 10. On [DATE] at 8:20am, the entrance door to the Covid-19 unit had signs documenting, Stop-Entrance Restricted-See Nurse. This door, which is adjacent to the main foyer and Administrators office, was standing open. On this unit was noted an uncovered linen cart. V12 was observed cleaning handrails on this unit. V12 was wearing a gown, gloves, N95 mask, and a face shield. V12 stated when leaving the unit, staff are to go into the beauty shop, which connects the unit to the foyer/front entrance, doff PPE and wash their hands at the sink. After this interview, V14 was observed leaving the unit through the open entrance door and going into V1's office located inside the foyer, without first doffing PPE and handwashing. V14 then came back onto the unit through the open unit entrance door. On [DATE] at 8:30 AM, a sign documenting, Isolation-See the Nurse was observed on R1's door. V23 (CNA) was observed in the room. V23 stated R1 is on contact and droplet isolation due to being positive for Covid-19. V23 stated this means staff are to don gown, gloves, an N95 mask, and a face shield before entering the room. V23 was not wearing a face shield and stated she left it in her bag. V23 then went to the foyer to retrieve the face shield without first doffing PPE and handwashing. V17 then re-entered the unit through the open entrance door. 11. On [DATE] at 11:33am, V12 stated that she is the Covid Unit CNA today, and that V1 is acting as the Unit nurse. V12 stated she was functioning as Unit CNA and also Housekeeping Supervisor that day. The surveyor observed a door on the unit that opens into the dining room of the facility in which residents from the dementia unit were observed preparing for lunch service. This door was noted to be unlocked. V12 stated the door is kept unlocked. V12 stated although no ambulatory residents have accessed the Covid unit from the dining room, V12 acknowledged it is possible that they could. The plastic tarp wall separating the Covid unit from the Long Term Care unit, which had been intact on [DATE], was noted to have come untacked and was allowing about 2 feet of airflow at both the top and bottom of the tarp, as well as a six inch gap on one side. On the other side of the tarp, an ambulatory resident could be seen walking in the hall of the Long Term Care Unit, within six feet of the tarp wall. This was pointed out to V12, who stated residents on the other side who self-propel in wheelchairs probably loosened the tarp accidentally, and V12 stated she would have to tell maintenance it needed to be fixed. From 11:33am to 12:20pm, no observations were made of V12 calling maintenance, nor of maintenance repairing the tarp. On [DATE] at 2:30pm, V18, Doctor of Osteopathy/Medical Director, stated he and V25, Advance Practice Nurse, have been doing telemedicine with the facility's residents for the past few months due to Covid-19 precautions. V18 stated his expectation is that any resident exhibiting the symptoms of Covid-19 infection should be isolated and their medical provider called immediately, and all infection control precautions should be followed to protect the residents, including proper use of PPE and hand hygiene. V18 stated when R4 presented with the low O2 sat, he or V25 should have been immediately contacted. V18 stated residents vital signs should be monitored every four hours and anything not within normal limits should be immediately addressed with the medical provider. On [DATE] at 12 pm, V25 stated she was unaware R4 had the low O2 sat prior to her being contacted. V25 stated the facility should have immediately notified her or V18. V25 stated she was aware of problems with the facility not monitoring residents vital signs per policy as the issue has presented itself during telemedicine appointments, with vital signs often not being available. A Notification for Change in Resident or Status Policy dated [DATE] stated, The facility and/or facility staff shall promptly notify appropriate individuals(.ie (the resident's)physician) of changes in the resident's medical/mental condition and/or status (including) any symptom, sign or symptom that is sudden in onset, a marked change(ie more severe) ,(and/or) unrelieved by measures already prescribed, (including) symptoms of an infectious process. A Covid-19 Control Measures Policy with an initially dated [DATE] and a revision date of [DATE] documented, Purpose: To prevent transmission of the Covid-19 Virus and to control outbreaks. Symptoms: Fever, cough, shortness of breath, nasal congestion, runny nose, sore throat, diarrhea/vomiting, extreme fatigue, muscle pain, loss of taste/smell PPE(Required): Require direct care staff and other staff members that may have close contact with residents to wear face masks, (and) eye protection(goggles/shield). All staff is to perform hand hygiene when exiting a residents room, after direct contact with residents or potentially contaminated surfaces(high touch areas). Contact Precautions: Implement when a resident is suspected of having any fever, respiratory symptoms, sore throat, nausea, vomiting, diarrhea, extreme fatigue, muscle pain loss of taste and/or smell change gloves and gown after contact with a resident and perform hand hygiene. Remove PPE when leaving a residents room. Monitoring and Surveillance-Residents: Monitor all residents for new onset of fever, cough, shortness of breath, sore throat, nausea, vomiting, diarrhea, extreme fatigue, muscle pain, and loss of taste or smell. Initiate contact and droplet (isolation) precautions for residents with respiratory symptoms, fever, sore throat Initiate temperature, pulse, respirations, and pulse oximetry every four hours and blood pressure every eight hours if a resident tests positive for Covid-19 or if residents have sign/symptoms of Covid-19. Monitoring and Surveillance-Employees: Screen all employees prior to the beginning of their shift and every four hours Screen all essential consultants and contracted staff upon entrance to the facility. Admissions and Readmissions: Newly admitted and readmitted residents whose Covid status is unknown should be placed in a private room and all recommended Covid-19 PPE should be worn during care .residents are to remain in a private room under observation for 14 days. Cohorting of Residents: Identify space within the facility to be dedicated to monitor and care for residents with Covid-19. Ideally, this space should be physically separated from other rooms that house residents without Covid-19. Counsel all residents to restrict themselves to their room as much as possible. An Infection Control Surveillance and Monitoring Policy with a revision date of [DATE] documented, Monitoring of the day to day operation of the Infection Control Program will be conducted by the DON. Included in these duties are: .C) Follows up on documentation of, and reporting of infection to physicians, through direct, random inspection of the clinical record with respect to: .2) Evaluation of parameters involved in assessment of physical condition, are evaluated and reported as appropriate(vital signs etc). A Room Roster dated [DATE] documented 55 residents living at the facility. An Immediate Jeopardy was identified to have begun on [DATE] when R4 was noted to be experiencing Covid-19 related symptoms such as uncontrollable coughing with a temperature of 99 degrees Fahrenheit and not being identified as being Covid-19 related. As R4's condition continued to deteriorate with O2 sat dropping to 66% percent with no medical intervention obtained R4 expired on [DATE] with one of the causes of death being novel corona covid-19. V1, Administrator was notified of the Immediate Jeopardy on [DATE] at 2:18pm. On [DATE] the surveyor confirmed through observation, interview, and record review, that the facility took the following actions to remove the Immediacy: The facility assigned V2 to begin inservicing the proper use of PPE on [DATE]. Staff were required to watch videos regarding hand washing and keeping COVID 19 out. Systematic & ongoing observations of infection control practices are being completed daily by supervisors on a rotation (each shift). Date completed: [DATE], with competency checks ongoing. The facility tracks all infections to determine patterns/trends, with V2 being responsible. Quality Assurance(QA) reviews are done daily, weekly and monthly. Date completed: [DATE] The facility assigned V2 and V25, Licensed Practical Nurse/Alzheimers Unit Coordinator, to complete daily Isolation audits. Date completed: [DATE] The facility assigned V2 to inservice staff regarding the facility Isolation Policy, starting on [DATE]. When the facility identifies a resident or staff member with any symptoms of COVID 19, (or having had a recent) emergency room visit or hospital stay, the resident will be automatically placed on a 14 day isolation period with a negative COVID test. A positive COVID test would be automatically placed in the COVID /droplet isolation Unit for 14 days. Date completed: [DATE] The facility assigned V2 to inservice staff regarding the facility policies for Physician Notification and Vital Signs, starting on [DATE]. The facility implemented daily QA review of 24 hour nursing report and review of telephone orders, and daily chart reviews to ensure vital signs and physician notification is completed as policy requires. Date completed: [DATE], and is ongoing. V27, Maintenance Director, placed a lock on the Dining Room door to address confused residents from potentially ambulating into the Covid Unit from the East side of Dining Room. Date completed: [DATE] V27 has re-enforced the temporary barrier wall and will monitor it daily to ensure the placement remains intact. Date completed: [DATE] All staff was educated that no one may self- screen prior to entrance into the facility. Screening documents, PPE, an infrared thermometer, alcohol based hand rub, and a roster where all staff are to sign in each day was placed at the only permitted entrance to facility for workers, vendors, etc. The screening is monitored periodically throughout the day and evening shift by V1, V2, to ensure all are screened and none in attendance are displaying the symptoms of Covid-19. Date completed: [DATE] The facility will continue to In-service staff regarding new directives regarding COVID. Any new directives are monitored daily by V1 and V2, and staff will be educated on any updates. This will be ongoing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E812	A. BUILDING _____ B. WING _____	**09/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MOUNT VERNON HEALTH CARE CENTER	**#5 DOCTORS PARK MOUNT VERNON, IL 62864**

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3)