STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145656	A. BUILDING _____ B. WING _____	**09/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INTEGRITY HC OF GODFREY	**1623 29 WEST DELMAR GODFREY, IL 62035**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop an infection control surveillance program related to COVID-19 for one resident, (Resident (R)2), who frequently left the facility for [MEDICAL TREATMENT]. This had the potential to affect all facility residents and staff. Findings include: On 09/16/20 at 10:30 AM, an interview with the Executive Director (ED), revealed the facility had one [MEDICAL TREATMENT] resident R2, who went out of the facility for [MEDICAL TREATMENT] every Monday, Wednesday, and Friday at 11:45 AM. The ED indicated R2 was under isolation precautions because of movement in and out of the facility which had the potential for putting R2 and other residents at risk. The ED indicated the facility did not have a surveillance system in place to monitor [MEDICAL TREATMENT] residents before leaving the facility nor upon return. The ED indicated every person who enters the building should complete the facility surveillance form and be monitored for fever. An interview on 09/16/20 at 12:05 PM, with the Director of Nursing (DON) who was also the facility's Infection Preventionist, revealed the facility had not developed a surveillance plan for [MEDICAL TREATMENT] residents. The DON indicated R2 was required to wear a mask when leaving and entering the facility, though no other surveillance was in place. The DON indicated R2 should complete the facility surveillance form and be monitored for temperature with each facility entry. On 09/16/20 at 2:15 PM, R2's [MEDICAL TREATMENT] tracking book was requested, but not supplied. The ED indicated the tracking book was incomplete and did not include assessment upon return from the [MEDICAL TREATMENT] facility for COVID-19 symptoms or a temperature check. The policy entitled, [MEDICAL CONDITION], Care of a Resident, revised September 2010, and provided by the ED revealed the policy did not address surveillance related to COVID-19 for residents who went out for [MEDICAL TREATMENT]. This was verified by the ED on 09/16/20 at 3:29 PM.

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.