| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **145502** | A. BUILDING _____ B. WING _____ | **10/12/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **TAYLORVILLE CARE CENTER** | **600 SOUTH HOUSTON TAYLORVILLE, IL 62568** |

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<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>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 3 of 3 residents (R1, R2, R3) reviewed for COVID-19 Infection Prevention and screening in a sample of 9. This has the potential to affect 3 residents identified as COVID-19 testing negative and employed staff providing services. Findings include: 1. On 10/6/20 at 10:10 AM, a 3-tier rolled linen cart, was stacked with clean linen on all three shelves, including the top shelf. The linen cart was outside room A4, which is identified as a COVID (+) resident room and stationed near several unidentified, (no markings to identify the wearer) Personal Protective Equipment (PPE), white gowns that were hanging on a wall, touching the clean linen cart. On 10/6/20 at 10:25 AM, V12 (Housekeeping) stated she was unsure of the purpose of the PPE gowns hanging up on the wall. On 10/6/20 at 11:40 AM, V11 (Registered Nurse/RN) stated she was unsure of the purpose of the PPE gowns hanging up on the wall, and stated the clean linen cart is utilized for the residents on the whole A-hall. 2. On 10/6/20 at 10:10 AM, a plastic sheet barrier was placed before entering rooms A5 through A12 for the positive COVID residents quarantined. Prior to entering the plastic quarantine barrier are rooms A3, A4, A13 and A14 which also include COVID (+) tested residents. Rooms A1, A2, and A16 are also before entering the plastic barrier and currently occupy COVID (-) residents with room doors observed as open. 3. On 10/6/20 at 11:00 AM, V15 (Certified Nurse Aide/CNA) left R2's room, COVID (-) tested resident and entered R4's room to assist V14 (Licensed Practical Nurse/LPN). V15 was wearing the same PPE gown after leaving R2's room, removed soiled gloves, no hand sanitation and no clean gloves applied. V15 applied her own personal gait belt to assist R4 from a fall, and readjusted the recliner and bedside roll table without gloves on. 4. R1's laboratory report documented R1 was COVID tested on [DATE], results returned on 10/6/20 at 11:52 AM as COVID (-) detected. R1's progress note to R1's physician, dated 10/6/2020 at 4:37 PM documented, R1's test result received as COVID positive. R1 resides on the A-Hall, unprotected from non-placement of the quarantine barrier, the placement of a clean linen cart, and the unidentified PPE gowns. On 10/6/20 at 1:00 PM, V1 (Administrator) stated some staff re-wear their initial PPE gown when entering the quarantine A-hall, when assisting the three current COVID (-) residents only to preserve the burn usage of PPE gowns. V1 stated she would expect staff to dispose of the gowns after the end of their work shift. V1 stated that the barrier was initially placed for the facility's emergency quarantine plan to block off rooms A5-A12 when the pandemic started and was never relocated in September, 2020 when the facility increased in COVID (+) residents to separate the COVID (+) residents from the COVID (-) residents. V1 stated she would expect all facility staff to wash or sanitize hands and apply clean gloves when entering a residents room, especially during this pandemic period. On 10/6/20 at 12:55 PM, V10 (Housekeeping Supervisor) stated the linen cart should have been covered and linen is not to be placed on the top shelf. V10 states Was there clean linen on the top shelf? The facility's policy entitled, Covid-19 Preparedness, dated 8/31/20, documented, a resident with known or suspected COVID-19, immediate infection prevention and control measures will be put into place, place the resident in contact/droplet isolation and close the door. The facility's policy, entitled, Laundry/Linen, documented, to ensure staff safety and enhance infection control, Do Not allow clean linen to touch clothing/uniform. |

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.