STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146092	A. BUILDING _____ B. WING _____	**09/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INTEGRITY HC OF HERRIN	**1900 NORTH PARK AVENUE HERRIN, IL 62948**

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 observation, interview, and record review the facility failed to follow recommended procedures for staff and visitor screening, and failed to correctly monitor the vital signs of residents (R3, R10, R11) who tested positive for Covid-19. This failure has the potential to effect all 25 residents who reside in the facility. The Findings Include: 1. Upon entering the facility on 9/18/20 at 8:45AM, the Illinois Department of Public Health Surveyors were greeted by V1(Administrator) and taken to the Administrator's office. The surveyors were not asked to wash hands, nor was a temperature taken or screening conducted for symptoms of COVID-19. Entry way had table set up with screening papers for staff and visitors with ABHS (alcohol-based hand sanitizer) available. No thermometer or screener was observed. At 10:00 AM, V9 (Dietary/Cook/Certified Nursing Assistant - CNA) was observed entering the facility without being screened, clocking in on the computer next to the administrator's office, walking through the dining area to the nursing station, and into the kitchen. At 10:08 AM when asked about the screening procedures for staff, V9 stated she took her temperature at the nursing station across from the kitchen and gave it to her supervisor V12 (Dietary Manager). V9 stated there is never anyone at the facility entry, but there are forms and ABHS there. V9 then stated we come to the nursing station and do temperature screening. At 10:07 AM, V1 stated staff screen themselves upon entry to the facility by filling out a questionnaire and using ABHS provided. V1 stated that staff screen themselves once a day by taking their temperature and logging their name. V1 said at this time, staff enter the facility and go to the nurses' station to take their temperature due to the front screening table thermometer not working. V12 will be going out to buy a replacement one now, therefore V9 had to walk through the facility without being fully screened to get a thermometer. V1 stated she will assign a person to screen employees as they enter at the start of shift going forward. At 10:30 AM, V4 (Housekeeping) stated staff help him fill the questionnaire and take his temperature because he needs help, but otherwise staff can do it themselves. V13 (Business Office Manager) stated at 10:45 AM, that she screens herself up at the nurses' station when she comes in for the start of her shift. The Visitation and Infection Control Policy updated to address the Coronavirus Disease 2019 (COVID-19) provided by the facility states that to prevent the spread of respiratory germs WITHIN the facility (from the Illinois Department of Public Health): to monitor employees prior to starting their shift for fever or respiratory symptoms. A 'no touch' forehead thermometer or tympanic thermometer is recommended. The policy further states that visitors shall be encouraged to wash their hands upon arrival and when leaving the facility. Resident records document the following in part - 2. A lab screening result form documents R3 tested for Covid-19 on 08/31/20 at 9:53 AM. Positive result dated 09/01/20 at 9:48 PM. Facility Isolation Monitoring Log documents R3 was placed on precautions on 09/01/20. On 09/02/20 at 11:17 AM, R3's record documents she was transferred to a sister facility that houses Covid-19 positive residents. There are no documented vital signs in R3's record after 08/30/20. 3. A lab screening result form documents R10 tested for Covid-19 on 08/24/20 at 10:04 AM. Positive result dated 08/26/20 at 6:09 PM. R10's record documents vital signs were taken once on 08/24/20 and once 08/25/20 during the 6:00 AM to 2:00 PM shift. A nursing note dated 08/26/20 at 12:12 AM documents R10 was transferred from the local hospital to the sister facility at this time due to running a fever of 103 degrees and testing positive for Covid-19. Facility Isolation Monitoring Log documents R10 was placed on precautions on 09/01/20 and transferred to a sister facility on 09/02/20. On 09/22/20 at 10:20 AM, when asked about the discrepancy in dates and times regarding R10's testing, isolation log, and nurses notes, V1 stated R10 had been sent to the hospital for an unrelated incident that occurred on the evening 08/25/20 and was in the hospital on [DATE], the day we received her Covid-19 results. V2 confirmed the hospital did their own Covid-19 test at this time due to R10 was running a fever, and stated their Facility Isolation Monitoring Log for R10 was incorrect. 4. A lab screening result form documents R11 tested for Covid-19 on 09/09/20 at 10:39 AM with positive result dated 09/10/20 at 7:54 PM. Facility Isolation Monitoring Log documents R11 was placed on precautions on 09/10/20, then transferred to sister facility Covid unit on 09/11/20. On 09/22/20 at 12:45 PM, V1 wrote via e-mail that R11's requested vital sign log was sent with R11 at the time of transfer on 09/11/20, and the sister facility was unable to locate them. There are no documented vital signs in R11's record after 09/08/20. On 09/18/20 at 10:10 AM, V2 (Director of Nursing - DON) stated R3, R10, and R11 were asymptomatic, but would have been placed on droplet isolation when positive lab result was received. V2 stated residents on quarantine or any type of isolation are to have their vital signs assessed q (every) 4 hours to include temperature, respirations, oxygen saturation, and pulse with blood pressure taken every 8 hours and should be documented. The Centers for Disease Control (CDC) website - https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html - Responding to Coronavirus (COVID-19) in Nursing Homes - Residents with new-onset, suspected or confirmed Covid-19 documents, Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections. Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms. An untitled facility document provided by V13 (Business Office Manager - BOM) and dated 9-22-20 confirms current facility census of 25.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE