

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 145229	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2020
NAME OF PROVIDER OF SUPPLIER HERITAGE HEALTH-SPRINGFIELD		STREET ADDRESS, CITY, STATE, ZIP 900 NORTH RUTLEDGE SPRINGFIELD, IL 62702	
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 - Few	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 isolation precautions for 2 of 4 residents (R2, R4) reviewed for infections, [MEDICAL CONDITIONS], in the sample of 4. Findings include: 1. R2's lab results, dated 02/27/20, documented a positive result of [MEDICAL CONDITION], ([MEDICAL CONDITION], infection of stool), with a treatment of [REDACTED]. On 3/16/20 at 2:10 PM, V6 stated the isolation precautions and appropriate personal protective equipment are to be applied prior to entering R2's room. On 3/16/20 at 2:20 PM, V6 entered R2's room, sat on his bed and was tying up a plastic bag R2 had in his possession earlier, containing food. V6 exited R2's room within 5 minutes. During this observation, V6 was not wearing protective gown or gloves while in R2's room. On 3/16/20 at 2:15 PM, V8 stated she would have expected V6 to have applied the appropriate personal protective equipment prior to entering R2's room. 2. R4's lab results, dated 11/03/19, documented a positive result of [MEDICAL CONDITION]. R4's Care Plan, dated 12/16/19, documented R2 requires contact isolation, related to [MEDICAL CONDITION], and hospital records indicating a 2-year history off and on with [MEDICAL CONDITION]. R2 remains on isolation due to continued loose stools. On 3/16/20 at 9:20 AM, V3, Certified Nurse Assistant, entered R4's room to attend to R4's family care needs. V3 removed soiled gloves, took the soiled bag out from the trash can, tied it up, then left R4's room. V3, with the soiled bag in her bare hand, entered another resident's room, activated call light, placed the soiled bag onto the floor, then proceeded to pick up soiled bag and exited room to dispose of bag. On 3/16/20 at 4:45 PM, V2, Interim Director of Nursing, stated she would have expected that all facility staff wash their hands after removing contaminated gloves and to not transfer contaminated articles to other residents un-contaminated room. The facility's policy and procedure, entitled [MEDICAL CONDITION] Protocol, undated, documented Trash and linen will be handled in the same manner as all trash and linen in the facility, good hand hygiene should be maintained by staff using soap and water and gloves should be worn when touching any potentially contaminated items and to include, [MEDICAL CONDITION] spores are transferred to residents mainly by the hands of any person who may have touched a contaminated surface or item.		

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