STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016190	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF PEORIA	6900 NORTH STALWORTH PEORIA, IL 61615

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3100d)2) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3100 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves	S9999		

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S9999	Continued From page 2 the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to interview the family of a confused resident to accurately assess elopement risk prior to admission, screen for supervision needs and develop an elopement care plan, failed to provide adequate supervision to prevent an elopement, failed to ensure all exit doors were secured and/or alarmed and the exit door alarm system was in working order, and failed to investigate an elopement for one of three residents (R27) reviewed for wandering in the sample of 27. These failures resulted in R27, a severely cognitively impaired resident with a diagnosis of Dementia, who is normally independent with ambulation and with a known history of eloping prior to admission to the facility, eloping from the facility on 5/30/22 and being found outside in the back of the building, walking across the grass heading towards the facility, from an unknown location. The facility was unaware that R27 was missing until V20 (Dietary Aide) observed R27 outside and notified facility staff. R27 was found and required extensive assistance of two staff members to return inside of the facility due to R27 being physically exhausted. Findings include: The facility's Missing Resident policy dated 2/25/19, states, "Purpose: To provide 24-hour supervision of the resident's safety. Staff	S9999		

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S9999	Continued From page 3 responsible: 1. Administrator 2. Maintenance 3. Director of Nursing 4. All Staff; Missing Resident: the following criteria shall be met prior to determining whether a resident is missing: The resident is not capable of making safe decisions regarding their safety and welfare and they are unattended. Procedure: All exterior doors shall be equipped with a signal that will alert staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device. 2. Residents at risk for wandering shall be assessed and addressed on the Care Plan. Immediately following the alarm signal, staff shall check the alarm panel and respond to the door indicated. Prevention: Check and test door alarms regularly, Identify and monitor residents at risk; Response to Resident Leaving the Building: Assist back to building, When resident returns to facility, a thorough exam should be completed, to assess for injuries; Missing Resident Protocol: The facility shall notify the resident's Physician and the legal representative or family member; Once the resident is found, an internal investigation will be conducted by the Administrator." R27's electronic medical record documents R27 was admitted to the facility on 5/4/22 with diagnoses which include, Dementia with behavioral disturbances, Cerebral Infarction with left sided weakness, Insomnia, Unsteadiness on feet, and Aphasia. R27's MDS (Minimum Data Set) assessment dated 5/10/22, documents the following: R27 has severely impaired cognition with short and long-term memory problems, wanders daily which places R27 at significant risk of getting to a potentially dangerous place (such as stairs, outside of the facility); and R27's wandering also	S9999		

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S9999	Continued From page 4 significantly intrudes on the privacy or activities of others. This same MDS assessment documents R27 ambulated once or twice with one staff assistance. R27's Elopement Risk Assessment dated 5/6/22 at 3:56 p.m., and completed by V13 (Activity Director), documents R27 is not at risk for elopement. R27's Care Plan initiated on 5/4/22, does not address R27 being a risk for elopement or wandering until it was revised on 6/1/22 (after R27 eloped on 5/30/22). This same Care Plan states, "Activities: R27's barriers are cognitive decline due to Dementia, physical and verbal behaviors to other residents and staff when upset about wanting to go home or see husband." R27's Behavior Tracking dated 5/10/22 through 5/30/22, does not document R27's exit seeking/wandering. R27's Progress Notes dated 5/14/22 9:50 a.m., state "R27 has continual supervision in waking hours. Unable to reorient. R27 does not remember fall occurring earlier in day. R27 self ambulates often raising her voice and cussing at staff." R27's Progress Notes dated 5/15/22 at 11:05 a.m., state, "R27 has to have one-on-one supervision at almost all times (due to) her behaviors and fall risk." R27's Progress Notes dated 5/16/22 at 10:19 a.m., state, "R27 states, 'My husband is not here yet. You hate me and I am not listening to you. I am tired of this bulls**t. I am leaving, maybe I will die'."	S9999		

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S9999	Continued From page 5 On 6/06/22 at 12:53 p.m., V25 (R27's Husband) stated that R27 lived at home with him prior to her hospitalization and admission to the facility on 5/4/22. V25 stated R27's Dementia was progressing, and she was no longer safe to stay at home with V25. V25 stated R27, "got lost three times in our hometown after she wandered off from home. Luckily, it's a small town and people knew who R27 was. R27 even went to (her old place of employment) and walked in like she was going to work. R27 can walk independently, and I take her on a lot of walks when I'm here. R27 has tried to leave this facility at least twice, according to staff. R27 says she wants to go home so she is frequently trying to get to an exit door. I can't remember the date that she tried to elope." R27's Nursing Progress Note dated 5/31/22 and completed by V2 (Director of Nursing) states, "Spoke with V25 that (R27) is an elopement risk and R27 had wandered out of the facility on 5/30/22 at approximately 7:20 p.m. and found by (the apartments down the street) and brought back by dietary staff member. No injury noted. R27 placed on frequent checks by night shift nurse and wander guard placed." R27's Nursing progress Note dated 5/31/22 at 12:42 p.m., states "Nursing implemented (wander management device) this morning." On 6/8/22 at 11:48 a.m., V20 (Dietary Aide) stated V20 was sitting outside of the service door (the exit door located by the kitchen) at the end of his shift on 5/30/22. V20 stated R27 came walking towards the facility, through the grass in the back of the building. V20 stated, "I have no idea where R27 came from or how she got out of the facility. I knew she needed help, so I ran inside the	S9999		

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S9999	Continued From page 6	S9999		

building and got V21(Cook) to come outside to help me with R27. I quickly tried to call nursing staff when V21 headed outside but no one answered the phone, so I went back outside to help V21 get R27. R27 was walking but appeared exhausted. It took V21 and I both taking R27 by the arms to assist her back inside to the nurse's station. R27 was worn out. I'm glad I saw her when I did, or I don't know what would have happened to her. There were no alarms heard from the kitchen. The (service door exit) does not have an alarm on it."

On 6/8/22 at 10:30 a.m., V21 (Cook) stated, "I was in the kitchen when V20 came running in telling me that R27 was outside by herself. V20 tried to call nursing staff for help, and I ran outside to R27. When I got to R27 she was completely exhausted. I have no idea where all she had been or how long she was outside. It took both V20 and I to hang on to R27 and help her to get back inside to the nurse. I didn't ever hear any alarms. The service door (exit by the kitchen) is not alarmed. The door that comes from the hallways to the kitchen area is unlocked by kitchen staff in the morning and not locked until approximately 8:00 p.m. at night."

On 6/8/22 at 9:34 a.m., V2 (Director of Nursing/DON) stated, "I was notified on 5/30/22 at approximately 8:00 p.m., that R27 had somehow gotten outside of the facility. R27 has a diagnosis of Dementia and cannot make safe decisions. Her cognition is severely impaired. I did not do any type of investigation after R27's elopement on 5/30/22. I just had nursing staff attach a (wander management device) on her clothes the next morning. R27's nurse V22(Registered Nurse/RN) did not document R27's elopement, an assessment of R27 to check

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S9999	Continued From page 7 for any type of injuries, or that R27's Physician or husband were notified of the elopement. I don't recall hearing R27 verbalize that she wanted to go home or that she had made attempts to leave the facility. I did call V1 (Administrator) on 5/30/22, after I was notified of R27 being found outside. We (facility staff) had been trying to find her alternative placement due to her behaviors. I did not know that R27 had a history of eloping when she was still living at home. I don't do the elopement risk assessments. Those assessments are completed by the Activity Director in this facility. The elopement risk assessment should have been completed with the assistance of R27's husband since R27 is confused. I have no idea if R27's Care Plan addressed her risk for elopement prior to 5/30/22. I have not watched any video surveillance or conducted any interviews with the staff that found (R27) outside or any other staff on duty on 5/30/22. I cannot say where she exited the building or how long she was outside. I screened R27 for admission to the facility. I don't recall reading anything about her history of elopement. I don't have any documentation of my screening that was completed prior to accepting R27. I don't recall what all I reviewed from the hospital. There is no specific form that I follow. I probably wouldn't have taken (R27 as a resident) if I had known she had a history of eloping at home. We aren't a locked unit. I absolutely would have made sure R27 had a (wander management device) in place on admission at the very least." On 6/8/22 at 9:50 a.m., V13 (Activity Director) stated R27 is very impulsive and easily becomes agitated. V13 stated, "I do a lot of one on one's with R27 and at times she is very hard to re-direct. I take her for a lot of walks because that seems to keep her content. She likes to be up	S9999		

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S9999	Continued From page 8 moving. R27 was admitted on 5/4/22 and I completed her Elopement Risk Assessment. I don't know why this facility has the Activity Director doing those assessments. I don't have access to residents' medical records or anything like that. I was not formally trained on completing the Elopement Risk Assessments. I don't recall involving V25 while completing R27's Elopement Risk assessment. I wasn't aware that R27 escaped from her home prior to admission. I would have made her high risk for elopement if I had known that. I don't make the decision to put a (wander management device) on residents. R27 is always telling staff she wants to go home and asking where V25 (R27's Husband) is. I know she has tried to get out the exit doors and she has done a lot of wandering since she was admitted." On 6/8/22 at 11:20 a.m., V1 (Administrator) stated V2 notified her of R27's elopement from the facility on the night of 5/30/22. V1 stated V1 did not consider it an actual "elopement because R27 was still on (facility owned property)." V1 stated R27 has severely impaired cognition and is not safe to be outside of the facility without supervision. V1 stated, "I thought V2 (DON) was handling the elopement issue. I told V2 to put a (wander management device) on R27 and do frequent checks. I have not completed any sort of investigation of R27's elopement on 5/30/22. I don't know what happened. V2 was responsible for the investigation at that point. We don't know what door R27 exited from or how long she was outside unsupervised. I do not have access to video surveillance and I'm not sure what is monitored by the video surveillance. I doubt the exit doors are on video. All exterior doors should be alarmed. Staff should have been aware of R27's history of elopement when she was	S9999		

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S9999	Continued From page 9 admitted if they had interviewed V25 (R27's Husband) or properly screened R27 prior to admission." On 6/6/22, at 11:10 a.m., R27 was ambulating independently towards the nurses' station, with no staff supervision. On 6/7/22 at 9:50 a.m., R27 was ambulating independently in the main hallway. On 6/8/22 at 9:47 a.m., R27 ambulated into V2's office and sat at the table. On 6/8/22 at 10:07 a.m., R27 was up independently ambulating in the common area with only socks on her feet. A staff member assisted R27 back to the wheelchair and took R27 to her room. On 6/08/22 at 10:40 am, R27 was ambulating on the main hall of the facility with standby assistance from staff. R27 repeatedly stated "get me out of this place" and "when am I going home." R27 had a small device attached with a clip to the hood of her sweatshirt. V2 (DON) was questioned as to what that device was. V2 stated the device was a "wander guard" that would alert staff if R27 passed through an exit door. V2 stated that the facility typically uses a "wander guard" that is placed on the resident's wrist or ankle as a bracelet, but they only have two of those devices and they are being used by other residents. On 6/8/22 at 3:30 p.m., R27 was walking outside with her husband. On 6/08/22 at 10:37 am, the facility was toured with V2 (DON) to identify all exterior doors and if	S9999		

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S9999	Continued From page 10	S9999		

they were secured and alarmed. The corridors that separate the Skilled Nursing side of the facility from the Assisted Living Side of the facility were not alarmed. V2 explained, at that time, that the only way a staff member would know if a resident went through those doors, was if they had a "wander guard" bracelet/alarm on. V2 then stated, R27 did not have a "wander guard" on when she eloped from the facility on 5/30/22, so R27 likely went through those doors into the Assisted Living portion of the facility. Once on the Assisted Living side of the building, the Service Entry door that leads to the Kitchen and another exterior door, was not locked, or alarmed. That exterior door led to the parking lot behind Assisted Living. At 10:45 am, V21 (Cook) stated that Service Entry door is unlocked and not alarmed from the time Kitchen staff arrive early in the morning, until they are gone at 8:00 pm. An additional exit door on the Frye Hall, which led directly to the parking lot in the front of the facility was able to be opened without an alarm sounding. V2 stated, at that time, that the exit door on Frye Hall should alarm when opened.

On 6/14/22 at 5:00am, the same fire doors that separate the Skilled Nursing Unit from the Assisted Living Unit were not alarmed. On 6/14/22 at 5:05 am, V22 (Registered Nurse/RN) was the only Licensed Nurse working 3rd shift. V22 was unaware of the Elopement Book. Upon further interview, V22 (RN) explained that R27 had attempted to elope two times the evening of 6/13/22, once out the front door and once out of the corridor that connects the Assisted Living Unit to the Skilled Nursing Unit. V22 verified that R27 was supposed to be on one-to-one supervision due to the elopements throughout the evening; however, V22 stated that the facility did not have the staff to provide 1:1 supervision and R27 was

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S9999	Continued From page 11 not on 1:1 supervision at the time. At 5:15 am, two additional staff, V36 (Agency Certified Nursing Assistant/ Agency CNA) and V38 (Cook) stated they had not received education as identified in the Abatement Plans. On 6/14/22 from 6:35 a.m.-6:37 a.m., The fire doors that separate the Skilled Nursing Unit from the Assisted Living Unit did not alarm on two separate instances when one visitor and one staff member V11(Registered Nurse/RN) came through those doors. On 6/14/22 at 5:21 a.m., review of the "Shift Door Check" sheet dated 6/13/22, did not document any of the 19 listed doors were checked to ensure they were properly functioning on the 2nd and 3rd shift. On 6/14/22, R27, R119, and R194's Care Plans had not been revised with resident specific interventions related to their elopement risk. (A) Statement of Licensure Violations (2 of 2) 300.696a) 300.696b) 300.696f)4) Section 300.696 Infection Prevention and Control a) A facility shall have an infection prevention and control program for the surveillance, investigation, prevention, and control of healthcare-associated infections and other infectious diseases. The program shall be under the management of the facility's infection preventionist who is qualified through education, training, experience, or certification in infection prevention and control.	S9999		

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S9999	Continued From page 12 b) Written policies and procedures for surveillance, investigation, prevention, and control of infectious agents and healthcare-associated infections in the facility shall be established and followed, including for the appropriate use of personal protective equipment as provided in the Centers for Disease Control and Prevention's Guideline for Isolation Precautions, Hospital Respiratory Protection Program Toolkit, and the Occupational Safety and Health Administration's Respiratory Protection Guidance. The policies and procedures must be consistent with and include the requirements of the Control of Communicable Diseases Code, and the Control of Sexually Transmissible Infections Code. f) Infectious Disease Surveillance Testing and Outbreak Response 4) Upon confirmation that a resident, staff member, volunteer, student, or student intern tests positive with an infectious disease, or displays symptoms consistent with an infectious disease, each facility shall take immediate steps to prevent the transmission by implementing practices that include but are not limited to cohorting, isolation and quarantine, environmental cleaning and disinfecting, hand hygiene, and use of appropriate personal protective equipment. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all employees were screened upon entrance to the facility for COVID-19 (Coronavirus Disease 2019) every day before their scheduled work shift, remove a	S9999		

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	IL6016190	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF PEORIA	6900 NORTH STALWORTH PEORIA, IL 61615

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S9999	Continued From page 13 symptomatic employee from work immediately and quarantine this employee, and failed to isolate residents who are unvaccinated or not up to date with the COVID-19 vaccination immediately after exposure to COVID-19 positive employees. These failures resulted in V4 and V6 (CNAs/Certified Nursing Assistant) continuing to provide direct care to all of the residents within the facility for three to five days after exhibiting symptoms of COVID-19 and eventually testing positive for COVID-19. These failures have the potential to affect all 30 residents within the facility, which is located in a high COVID-19 transmission area according to the Centers for Disease Control and Prevention (CDC) COVID-19 data tracker. Findings include: The Resident Census and Conditions of Residents, CMS (Centers for Medicare & Medicaid Services), Form 672 dated 6-7-22 documents 30 residents reside within the facility. The CDC COVID-19 Data Tracker dated 6-2-22 through 6-7-22 documents COVID-19 Community Level of contracting COVID-19 as High for Peoria County, Illinois (the county the facility is within). The facility's COVID-19 policy dated 1-19-22 documents, "The infection control program at this facility recognizes novel Coronavirus (COVID-19) as a highly contagious virus and has a focus to reduce the risk of unnecessary exposures among residents, staff, and visitors. Measures are based on guidance from the Centers for Disease Control (CDC), Center for Medicare and Medicaid Services (CMS) and state and local authorities. Interventions focus on prevention of exposure, early detection of symptoms, effective triage, and	S9999		

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S9999	Continued From page 14 isolation of potentially infectious residents. Screening: All people upon entering the facility must self-screen at designated area for signs and symptoms of COVID-19 based on the most current recommendations of CMS, CDC, and State Department of Public Health. Documented screening forms will be kept for at least 30 days. Facility will use the CDC COVID-19 Data Tracker Website to carefully monitor the color-coding, which depicts county community transmission levels. Staff who are not moderately to severely immunocompromised may return to work after ten days or may return to work after seven days if asymptomatic or have mild to moderate symptoms that are improving and fever-free for 24 hours. Must have one negative test completed within 48 hours before work shift begins or rapid antigen test prior to shift. Exposure Definition: Exposure is defined as being within six feet of a person with confirmed COVID-19 infection or having unprotected direct contact with infectious secretions or excretions of the person with confirmed COVID-19 infection." The CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated 2-2-22 documents, "Establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following three criteria so that they can be properly managed: A positive viral test for SARS-CoV-2 (Severe Acute Respiratory Syndrome Coronavirus), symptoms of COVID-19, or close contact with someone with SARS-CoV-2 infection or a higher-risk exposure (for healthcare personnel (HCP). Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can	S9999		

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MANOR COURT OF PEORIA	6900 NORTH STALWORTH PEORIA, IL 61615

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S9999	Continued From page 15	S9999		

self-report any of the above before entering the facility. HCP should report any of the 3 above criteria to occupational health or another point of contact designated by the facility, even if they are up to date with all recommended COVID-19 vaccine doses. Recommendations for evaluation and work restriction of these HCP are in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2."

The facility's COVID-19 Screening Checklist for Visitors, Vendors, and Employees dated 1-7-22 documents that if any visitor, vendor, or employee is experiencing any of the following symptoms, they are to be restricted from entering the building: fever, chills, fatigue, diarrhea, congestion, runny nose, nausea/vomiting, headache, sore throat, new/worsening cough, muscle/body aches, new loss of taste of smell, and shortness of breath, or difficulty breathing.

The CDC (Centers for Disease Control and Prevention) Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 (Severe Acute Respiratory Syndrome Coronavirus) Spread in Nursing Homes & Long-Term Care Facilities Website dated February 2, 2022 documents, "Manage residents who had close contact with someone with SARS-CoV-2 Infection: Residents who are not up to date with all recommended COVID-19 (Coronavirus Disease 2019) vaccine doses and who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine after their exposure, even if viral testing is negative. HCP (Health Care Personnel) caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator). Residents can be removed from

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	IL6016190	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF PEORIA	6900 NORTH STALWORTH PEORIA, IL 61615

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S9999	Continued From page 16 Transmission-Based Precautions after day 10 following the exposure if they do not develop symptoms. Residents can be removed from Transmission-Based Precautions after day 7 following the exposure if a viral test is negative for SARS-CoV-2 and they do not develop symptoms." The facility's Infection Control Communicable Disease Testing policy dated 3-15-22 documents, "The facility shall conduct testing of residents and staff for the control or detection of communicable disease in the following situations: The facility is experiencing an outbreak. The facility is directed by the department or the certified local health department where the chance of transmission is high, including, but not limited to, regional outbreaks, pandemics, or epidemics. COVID-19 Testing: c. Facility may utilize rapid point of care tests if available and appropriate. Trained licensed staff will be utilized to obtain the tests. Routine testing for unvaccinated facility staff only will be based on the extent of the virus in the community using the level of community transmission in the past week. High (red)-minimum of twice a week testing. Facility staff will include employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents. Facility will prioritize those individuals who are in the facility on a weekly basis. Any staff that has a fever or exhibit symptoms will be tested." The (Brand Name) COVID-19 Antigen Rapid Test Manufacturer's Instructions dated 12/2021 for use document, "A positive result must show both a c (control) line and a t (test) line. A positive result means that viral antigens from COVID-19 were detected and the individual is positive for COVID-19. Persons who test positive should	S9999		

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MANOR COURT OF PEORIA	6900 NORTH STALWORTH PEORIA, IL 61615

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S9999	Continued From page 17 self-isolate and seek follow up care with their Physician or healthcare provider as additional testing and public health reporting may be necessary. The t line may be faint and is evidence of a positive test." The (Brand Name) COVID-19 Card Rapid Test Manufacturer's Instructions dated 12/2020 document, "Peel off adhesive liner from the right edge of the test card. Close and securely seal the card. Read result in the window 15 minutes after closing the card. In order to ensure proper test performance, it is important to read the result promptly at 15 minutes, and not before. False negative results can occur if test results are read before the 15 minutes." On 06/06/22 at 2:00 PM, V6 (Certified Nursing Assistant/ CNA) stated, "I was not tested for COVID-19 until 6-3-22 when I tested positive for COVID-19. I started feeling sick on Monday (5-30-22) and for the rest of the week. I had a runny nose, chills and a mucousy cough. I brought a space heater to work because I was chilling so bad. I did not do the pre-screening for COVID before my shifts. The screening is located in another building and that door is locked, so I cannot get to the screening. I took care of all of the residents in the building every day I worked last week." V6 stated, "I was supposed to test myself for COVID-19 last Thursday (6-2-22) at 10:00 PM but there were no rapid COVID tests available for me to test. All of the tests were locked up in V2's (Director of Nursing/DON) office. I worked that night from 10:00 PM through 6:00 AM (6-3-22). V2 came in at 6:00 AM on Friday (6-3-22) and I tested positive for COVID. I was sick all last week. On 06/06/22 at 2:15 PM, V4 (Certified Nursing	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF PEORIA	6900 NORTH STALWORTH PEORIA, IL 61615

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S9999	Continued From page 18	S9999		

Assistant/CNA) stated, "I tested myself for COVID-19 using a (Brand Name Covid 19 Antigen Rapid Test) rapid test on Saturday (6-4-22) around 10:30 AM when I went out to my car for break. The test came back positive. I had worked since 2:00 AM that morning.
I took the test into V3(Licensed Practical Nurse/LPN) and showed her it was positive. V3 took a different rapid test and re-tested me and (V3 told me it was negative and to go ahead and work. I worked until 2:00 PM that day and worked Sunday (6-5-22) from 2:00 AM through 2:00 PM and worked Monday (6-6-22) starting at 4:00 AM. On Monday (6-6-22) around 8:05 AM, V2 (DON) came in and said that the test V3 swabbed me with (on 6-4-22) had a positive result. V3 (LPN) had put my test result card in V2's office box. V2 noticed the test was positive and had me re-test. The rapid test V2 obtained on me was positive for COVID, so I was sent home. I had worked with all of the residents on every shift I worked on Saturday, Sunday, and Monday. I have had the Pfizer COVID vaccine and I have been boosted."

V6's Time and Attendance Employee Punch History dated 5-30-22 through 6-2-22 documents V6 worked on 5-30-22 from 10:03 PM through 6-1-22 at 6:08 PM, 6-1-22 from 10:15 PM through 6-2-22 at 6:20 AM, and 6-2-22 from 10:10 PM through 6-3-22 at 6:08 AM.

V4's Time and Attendance Employee Punch History dated 6-4-22 through 6-6-22 documents V4 worked on 6-4-22 from 2:04 AM through 2:03 PM, 6-5-22 from 1:58 AM through 2:01 PM, and 6-6-22 from 3:59 AM through 8:05 AM.

The facility's COVID-19 Screening Checklists for Visitors, Vendors, and Employees dated 5-1-22 through 6-4-22, do not include any screening

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S9999	Continued From page 19 checklists for V6 (CNA). On 06/06/22 at 1:45 PM, V3 (LPN) stated, "V4 took a rapid COVID test out to her car and tested herself on (6-4-22). V4 brought the test to me showing me she had a faint line indicating she was positive for COVID. V4 had used the (Brand Name) antigen rapid COVID test. The staff are able to use either the (Brand Name A) rapid test or the (Brand Name B) COVID antigen rapid test. I took a (Brand Name B) test and re-tested V4. I waited five minutes to read the test and it was negative. I told V4 she was negative and let her stay at work. I took V4's test and placed it in a biohazard bag and placed it into V2's (DON) office box. I put all COVID tests that are done over the weekend in V2's box. The staff are able to test themselves for COVID." On 6/7/22 at 10:20 a.m., V10 (Housekeeper) stated she is tested for COVID-19 twice a week, and she is allowed to swab herself and wait about 15 minutes for results. On 6/7/22 at 10:30 a.m., V11 (Certified Nursing Assistant/CNA) stated she is tested for COVID-19 on Mondays and Thursdays, and she swabs herself. V11 stated, "Whoever the nurse is will let us know if there is an issue with the test, like if it's positive." On 6/8/22 at 10:36 a.m., V12 (Certified Nursing Assistant/CNA) stated she is tested for COVID-19 twice a week and she swabs herself. V12 stated, "I wait about five minutes for the results (of the COVID-19 test) then go to the floor." On 6/7/22 at 10:25 AM, V9 (Certified Nursing Assistant/CNA) stated, "Right now, we are testing two times a week due to having some positive	S9999		

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S9999	Continued From page 20 cases. I get here between two and four in the morning, and I get off at two in the afternoon. I am due to test today and I normally do that whenever V2 (DON) gets here. She is here now but I have not tested today. V2 will usually send a message and let us know when are to go to her office and test. When I am tested, I swab myself, and then V2 confirms the results. On the weekends, the on-duty nurse gets the test for me, and I swab myself and then the nurse verifies the results." On 06/06/22 at 2:30 PM, V2 (DON) stated, "I did not know that V4 (CNA) had tested herself and was positive. V4 should have gone home as soon as, she was positive. I also did not know that (V3) did not do the COVID rapid test right by waiting 15 minutes before reading the result. When I got to work, I noticed (V4's) COVID test had a line showing it was positive, so I had (V4) do another test on that following Monday and it was positive. (V4) should not have worked while having symptoms of COVID-19 and while testing positive for COVID-19. (V6) did not have a COVID-19 rapid test available for her to test herself, and I live over 45 minutes away from the facility and was not going to come in to get a test for her. The employees are supposed to test every Monday and Thursday. The CDC COVID-19 webpage dated 5-24-22 documents: "Vaccines: Primary Series: Doses of Pfizer-BioNTech given three to eight weeks apart. Fully Vaccinated: Two weeks after final dose in primary series. Boosters: One booster for most people at least five months after the final dose in the primary series. Second booster of either Pfizer-BioNTech or Moderna COVID-19 vaccine for adults ages 50 years and older at least four months after the first booster. Up to Date:	S9999		

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	IL6016190	A. BUILDING: _____ B. WING _____	06/16/2022

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MANOR COURT OF PEORIA	6900 NORTH STALWORTH PEORIA, IL 61615

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S9999	Continued From page 21 Immediately after getting all boosters recommended for you." The facility's COVID-19 Vaccine Resident Tracking documents R8's initial COVID-19 vaccination two doses were finished on 10-30-21 and R8 refused the Pfizer boosters. This same tracking documents R30 refused the COVID-19 vaccinations. On 6-6-22 at 8:45 AM and 6-7-22 at 3:10 PM, R30 was lying in his bed in his room. R30 was not in isolation at these times. R30 stated he does not want the COVID-19 vaccination. On 6-6-22 at 12:10 PM, R8 was self-propelling her wheelchair up the hallway and into her room. R8 stated that she does not want a COVID-19 booster and has not been in isolation. R8 was not in isolation at this time. On 6-7-22 at 3:10 PM, R8 was in bed in her room. R8 was not in isolation at this time. On 06/06/22 at 2:30 PM, V2 (DON) stated, "I did not know that V4 had symptoms of COVID-19, or that V4 was not screened for COVID-19 symptoms prior to her shifts. V4 should not have worked while having symptoms of COVID-19. All employees are supposed to screen themselves for COVID-19 prior to working their shifts and immediately upon entering the facility. R8 and R30 have not been put in isolation." On 6-9-22 at 2:00 PM, R30 was self-propelling up the hallway in her wheelchair and R8 was lying in bed. Neither R8 nor R30 were in contact/droplet isolation precautions On 6-13-22 from 9:45 AM through 10:15 AM, V30	S9999		

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S9999	Continued From page 22 (Agency LPN), V31 (Physical Therapy Assistant), V32 (Occupational Therapy Assistant) and V33 (Housekeeper) stated that they had not been educated or in-serviced regarding anything within the past two weeks including COVID-19 pre-screening prior to work, performing COVID-19 testing, reporting signs and symptoms of COVID-19 immediately, and removing staff immediately with any signs and symptoms of COVID-19. On 6-14-22 from 5:05 am to 5:15 am, V22 (Registered Nurse/RN) could not reiterate any education provided by Administrative staff in the last week and V37 (Agency Certified Nursing Assistant) and V38 (Cook) stated they had not received any education or in-servicing regarding COVID -19 pre-screening prior to work, performing COVID-19 testing, reporting signs and symptoms of COVID-19 immediately, and removing staff immediately with any signs and symptoms of COVID-19. (A)	S9999		