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S 000	Initial Comments Complaint Survey: 2327417/IL164079	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.696a) 300.697a) 300.697c) 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 300.696 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 1 Section 300.697 Infection Preventionists A facility shall designate a person or persons as Infection Preventionists (IP) to develop and implement policies governing control of infections and communicable diseases. The IPs shall be qualified through education, training, experience, or certification or a combination of such qualifications. The IP's qualifications shall be documented and shall be made available for inspection by the Department. (Section 2-213(d) of the Act). The facility ' s infection prevention and control program as required by Section 300.696(e) shall be under the management of an IP. a) IPs shall complete, or provide proof of completion of, initial infection control and prevention training, provided by CDC or equivalent training, covering topics listed in subsection (b)(1) to the facility, within 30 days after accepting an IP position. Documentation of required initial infection control and prevention training shall be maintained in the employee file. c) A facility shall have at least one IP on-site for a minimum of 20 hours per week to develop and implement policies governing prevention and control of infectious diseases. These Requirements were not et as evidenced by: Based on observation, interview, and record review, the facility failed to implement infection control procedures of testing COVID-19 symptomatic staff members, perform contact tracing testing on staff and residents with direct exposure to the COVID-19 positive staff member	S9999		

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and resident, and perform facility wide testing to prevent the potential spread of a highly contagious and potentially deadly disease to residents and staff. Direct care staff, while working with signs and symptoms of COVID-19 (headache, fatigue, and body aches) unnecessarily exposed residents to an infectious disease. These failures had the potential to affect all 77 residents residing within the facility. These failures resulted in R6 being hospitalized with the diagnosis of COVID-19 pneumonia.

Findings include:

The CDC (Centers for Disease Control and Prevention) COVID-19 Potential Exposure at Work, dated 9/23/22, documents, "Following a higher-risk exposure, HCP (healthcare professionals) should: Have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5."

The facility's Interim COVID-19 Testing Residents and Staff policy, dated 5/12/23, documents, "Testing of Symptomatic Residents and Staff: Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-1 as soon as possible. If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular PCR) or a second negative antigen test taken 48 hours after their first negative test and maintain transmission-based precautions until results are confirmed. Staff with signs and symptoms of

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S9999	Continued From page 3 COVID-19 must be tested and are expected to be restricted from the facility pending the results of COVID-19 testing. Staff who do not test positive for COVID-19 but have symptoms should follow facility policies to determine when they can return to work. Resident close contact exposures-Testing & Quarantine: Close contact is defined as being within six feet for a cumulative total of 15 minutes or more over a 24-hour period with someone with SARS-CoV-2 infection. These residents should still wear source control if able and should be tested as described below: Test #1 Immediately (but not earlier than 24 hours after the exposure). Test #2: If the 1st test was negative, test again 48 hours after the first negative test, and test #3: If the 2nd test was negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. Following the the exposure, the asymptomatic healthcare profession should be tested as follows: Test #1 Immediately (but not earlier than 24 hours after the exposure). Test #2: If the 1st test was negative, test again 48 hours after the first negative test, and test #3: If the 2nd test was negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. A single new case of SARS-CoV-2 infection in any healthcare professionals or resident should be evaluated to determine if others in the facility could have been exposed by completing contact tracing investigation. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach. However, a broad-based (e.g., affected unit, floor, department or other specific area (s) of the facility or facility-wide testing approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing	S9999		

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fails to halt transmission. Perform testing for all residents and healthcare professionals identified as close contacts or on the affected unit (s) if using a broad-based approach, regardless of vaccination status. Initial outbreak testing is recommended: Immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. If additional cases are identified in in the initial outbreak testing and the facility has switched to the broad-based approach, testing should continue on affected unit (s) or facility-wide every 3-7 days until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every 3 days), should be considered. Documentation of testing: For symptomatic residents and staff, document the date(s) and time(s) of the identification of signs or symptoms, when testing was conducted, when results were obtained, and the actions the facility took based on the results. Upon identification of a new COVID-19 case in the facility (i.e., outbreak), document the date the case was identified, the date that all other residents and staff are tested, the dates that staff and residents who tested negative are retested, and the results of all tests."

On 9/11/23 at 8:50 a.m., the facility's main entry door held a sign stating that the facility had COVID-19 positive cases within the facility.

A 3rd shift facility Assignment sheet, dated 8/15/23, documents that V4 (CNA-Certified Nursing Assistant) worked 3rd shift with V30 (CNA) and V36 (LPN-Licensed Practical Nurse) on the facility's B wing.

On 9/18/23 at 10:10 a.m., V4 stated that she called off work sick on 8/16/23 with COVID-19

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like symptoms. V4 also stated, "When I went to the ER (Emergency Room) on 8/16/23, I had nausea, body aches, and a migraine. They (ER) didn't test me there. I notified the scheduler (V15) that evening that I wasn't coming in. I never once was asked to test after I called off on 8/16/23."

On 9/14/23 at 11:10 a.m., V15 confirmed that she was aware that V4 called off on 8/16/23 for being sick.

On 9/14/23 at 11:25 a.m., V14 (Human Resources) stated, "I was aware that (V4) called off on 8/16/23, but I didn't know why. I think she gave me the ER note, but I didn't read it." V14 provided a hospital note, dated 8/17/23, that documents, "(V4) was seen and treated in our emergency department on 8/17/23." V14 stated, "I got this note, but I don't know why she was in the ER."

The facility's COVID-19 Testing log, no date but provided by V1 (Administrator) on 9/13/23, has no documentation of V4 being COVID-19 tested following V4 calling off sick on 8/16/23.

A 2nd shift facility Assignment sheet, dated 8/19/23, documents that V4 worked 2nd shift with V31 (Agency RN-Registered Nurse), V33 (Agency CNA), V34 (Agency CNA), and V35 (Agency CNA) on the facility's A wing.

A 3rd shift facility assignment sheet, dated 8/19/23, documents that V4 worked with V3 (Nurse Supervisor LPN) and V11 (CNA) on the facility's A Wing.

A 3rd shift facility assignment sheet, dated 8/20/23, documents that V4 worked with V23 (Agency Registered Nurse) and V11 on the

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facility's A Wing. The assignment sheet also documents that V3 worked until 10:00 p.m. on the A wing as well.

On 9/13/23 at 2:15 p.m. V4 stated, "I worked on 8/19/23 and still felt really sick. I was sick to my stomach, dizzy, runny nose, body aches, and just drained. It kept getting worse. So, when I came in on 8/20/23 at 10:00 p.m., (V3) was working so I told her I was still feeling sick, and my son was sick at home. It was around shift change so she told me she would leave some rapid tests out for me. I tested not once but twice, and the nurse (V23) was right there watching. She saw the positives as well. I took a picture and sent them to (V3) to let her know I was positive, and she sent me home. The next day, (V14 Human Resources) called and said I needed to come back to test. I was super sick and didn't have anyone to drive me in. So, I told her I wouldn't be able to come in."

On 9/18/23 at 10:10 a.m., V4 stated, "When I came back to work on 8/19/23, I was still having the headaches, nausea, and fatigue. I pushed through the symptoms to try and get my work done. The next night (8/20/23), the symptoms were real bad. I was so drained with fatigue and my body was hurting. I worked through my first set of rounds at 12:00 a.m. Then I tested myself. I notified V3 and sent her pictures of the positive test results at 12:59 a.m. After speaking to her and (V23), I went home."

V4's Timecard, dated 9/14/23, documents that V4 worked on 8/19/23 from 8:42 p.m. to 6:00 a.m. and 8/20/23 from 10:09 p.m. to 1:18 a.m.

On 9/13/23 at 2:45 p.m., V3 stated, "That night (V4) told me that she was sick, and someone in

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her household was sick. So, she thought she should test. It was shift change, and I didn't have any tests. So, I sent her to the other hall to test. After I left, she contacted me and told me that she had tested positive. We agreed that she should go home, and I notified (V2 Director of Nursing) the following day."

On 9/13/23 at 1:10 PM, V11 stated, "I worked with (V4) on 8/19 and 8/20/23. On 8/19/23, (V4) was acting weird, and kind of avoiding us like she didn't feel good. On 8/20/23, (V3) was working when (V4) came in and said she wasn't feeling well. (V4) also said her son was sick at home as well. (V3) asked her if she thought she needed to test and (V4) agreed. However, (V3) never tested her because it was around shift change. (V23) ended up getting a test out for (V4) and (V4) tested herself. (V23) and the other nurse looked at the results which were positive and told (V4) she needed to go home since it was positive. (V4) worked for a while before she went home on 8/20/23. I worked with (V4) the whole weekend, but the facility has never tested me to this day."

On 9/14/23 at 2:00 p.m., V23 stated, "I gave (V4) the COVID-19 tests to take. She was pretty sick. I watched her swab herself, and I confirmed that they were both positive. I watched her take a picture of them and send them to (V3). After she told (V3) she was positive she went home. I generally work A-hall when I'm in the facility. I have not been tested at all by the facility since (V4) or (R3) tested positive, and I worked there after that."

On 9/18/23 at 3:00 p.m., V31 stated, "I was not aware that I was exposed to a staff member who was COVID-19 positive. I knew I had taken care of (R3) and (R16) prior to them testing positive,

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but not a staff member that I had worked with. I have never been tested by the facility, nor has my agency tested me."

The facility's COVID-19 Testing log, no date but provided by V1 on 9/13/23, documents that resident COVID-19 testing was initiated on 8/22/23 for residents only residing on the A-Wing. The log has no documentation of contact tracing testing for those in direct contact of V4 while V4 was symptomatic beginning on 8/15/23 including, B wing residents, V11, V23, V30, V31, V33, V34, V35, and V36.

The facility Resident COVID-19-line list, no date but provided on 9/11/23 by V1, documents that R3 tested positive for facility acquired COVID-19 on 8/22/23.

R3's Nurses note, dated 8/22/23 at 5:30 p.m., document, "Narrative: Resident tested COVID-19 positive and placed into contact and droplet isolation. Resident asymptomatic."

A 1st shift facility assignment sheet, dated 8/21/23, documents that V24 (Agency LPN), V9 (CNA), V10 CNA, and V45 (CNA) were assigned to the facility's A-wing putting them in direct contact with R3.

A 2nd shift facility assignment sheet, dated 8/21/23, documents that V24, V28 (CNA), V37 (CNA), and V40 (Agency CNA) were assigned to the facility's A-wing putting them in direct contact with R3.

A 3rd shift facility assignment sheet, dated 8/21/23, documents that V41 (Agency LPN), and V42 (Agency CNA) were assigned to the facility's A-wing putting them in direct contact with R3.

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A 1st shift facility assignment sheet, dated 8/22/23, documents that V24, V38 (CNA), V10, and V43 (Agency CNA) were assigned to A-wing putting them in direct contact with R3.

A 2nd shift facility assignment sheet, dated 8/22/23, documents that V24, V44 (Agency CNA), V39 (CNA), and V40 were assigned to A-wing putting them in direct contact with R3.

The facility's COVID-19 Testing log, no date but provided by V1 on 9/13/23, documents that CNAs and nurses working with R3 on 8/22/23 2nd shift and 8/23/23 1st were the only staff members, with the exception of department heads, that were initially tested following R3's COVID-19 positive diagnosis. The log has no documentation of the direct exposure staff members (V9, V24, V28, V37, V39, V40, V43, V44) tested on 8/22 and 8/23/23 receiving the 2nd and 3rd testing in the sequence of contact tracing testing. There is also no documentation of V10, V38, V41, V42, or V45, who had direct contact/exposure with R3, receiving contact tracing testing.

On 9/14/23 at 2:40 p.m., V24 stated, "I worked with (R3) before right before the outbreak and after. I've never been tested until just last week."

The facility's COVID-19 testing log, no date but provided by V1 on 9/13/23, documents that V24 was initially tested for COVID-19 on 8/23/23. The only other testing that V24 had received was on 9/8/23.

The facility's Resident COVID-19-line listing, no date but provided by V1 on 9/11/23, documents that R6 tested positive for facility acquired COVID-19 on 8/24/23.

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R6's Nurses notes, dated 8/24/23 at 9:30 a.m., document, "Resident tested COVID-19 positive. Resident remains asymptomatic. Resident moved from yellow zone quarantine to red zone isolation."

R6's Alert note, dated 8/28/23 at 3:24 a.m., documents, "The resident was sent out to hospital due to oxygen stats dropping. Went into the resident room around bedtime to give medications. The resident was halfway out of bed and did not look well. Resident vitals were checked, and results were blood pressure 166/85, pulse 70, respirations 24, temperature 96.7, sp02 (oxygen saturation) 70% (on room air). The resident was placed on oxygen at 4L (liters) stats increased to 97%. Doctor was notified of the situation and gave verbal orders to send residents out if stats dropped again. Resident stats were monitored throughout the shift up until 3 am. Resident stats dropped between 87-88% on 2L. wheezing was heard in both upper lungs along with rapid breathing."

R6's Hospital Critical Care Admission History & Physical, dated 9/3/23, documents, "R6 is sent over from nursing for increasing oxygen requirement. He had increased work of breathing in the ED (emergency department) was placed on BiPAP (bilevel positive airway pressure). Respiratory symptoms possibly secondary to COVID-19 pneumonia versus heart failure exacerbation. He tested COVID-19 Testing log, no date but provided by V1 on 9/13/23, documents that testing for all residents residing on the B wing was not initiated until 9/8/23.

The facility's Absence/Tardy Report, dated 8/27/23, documents that V28 called off on this

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date because she was not feeling well. The report also documents, "Directed her to come to facility for COVID-19 test."

The facility Absence/Tardy Report, dated 8/30/23, documents that V28 called off at 1:00 p.m. for her shift that was to begin on that date at 2:00 p.m. because she was "still not feeling well."

The facility COVID-19 Testing log, no date provided on 9/13/23, documents that the only testing that V28 received was on 8/22/23, 9/8/23, and 9/12/23.

The facility's Absence/Tardy Reports, dated 8/28, 8/29, 8/30, and 9/1/23, all document that V29 (laundry aide) called off on those days for symptoms of cough, sore throat, chills, chest hurting, head hurting, no energy, and troubles breathing.

The facility's COVID-19 Testing log, no date but provided by V1 on 9/13/23, documents that V29 was not tested until 9/8/23 and 9/12/23.

On 9/18/23 at 9:55 a.m., V29 stated, "I tested the first day I called in on 8/28/23 and it was negative. That was the only COVID-19 test I got until 9/8/23. I didn't have to test when I came back to work."

The facility's Absence/Tardy Report, dated 8/31/23, documents that V30 (CNA) called off on this date at 7:38 p.m. for her 10 p.m. shift because she was "not feeling well."

The facility's COVID-19 Testing log, no date but provided by V1 on 9/11/23, documents that V30 was not COVID-19 tested until 9/2/23.

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(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
S9999	Continued From page 12 On 9/18/23 at 1:50 p.m., V32 (Agency CNA) stated, "I'm agency and I normally work here at least three or four times a month. I've never been COVID-19 tested by this facility, and my agency doesn't test us either." On 9/14/23 at 1:15 p.m., V2 (Director of Nursing) stated, "Infection Preventionist (IP) monitors the Employee Illness log. All managers take their own call offs then notify IP. If staff report being sick, they are rapid COVID-19 tested and sent home. If it's after hours, then the nurse who is working is responsible for swabbing the staff member. If that is negative, they are sent home and required to retest in 48 hours. A negative is needed at that time to return to work. We found out on Monday (8/21/23) that (V4) supposedly tested positive. (V4) reported that she self-swabbed. So, we don't accept that. We needed her to come in to confirm her results. Since we weren't able to confirm that she was positive we presumed, she was positive. That is why we initiated testing. I'm not aware of her calling off sick on 8/16/23. If she called off for COVID-19 related symptoms, then she should have been tested. We tested all of the residents on A-Wing and the staff that worked on that hall. The staff working (A-hall) 8/22/23 on 2nd shift were all tested. On 9/8/23 we initiated all residents and all staff to make sure we didn't get out of outbreak and had more positive. We didn't' have to do that, but we wanted to be safe. Once we got through day 1, day 3, and day 5, we went to twice a week testing. If agency staff are here during outbreak they should be being tested." V2 confirmed that V11, V31, V33, V34, and V35 have not had any COVID-19 testing completed. On 9/18/23 at 3:15 p.m., V1 (Administrator) stated, "When agency staff call off, we don't know the reasoning of calling off. It is all scheduled	S9999		

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	IL6006399	A. BUILDING: _____ B. WING _____	C 09/19/2023

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through an application. If an agency staff member is calling off, we get notified of a cancellation, and that is it. We don't call the agency to find out the reason of calling off. So, we have no way of knowing if they are sick. We do not test our agency staff, nor do we require them to test before coming back to work after calling off."

On 9/13/23 at 8:35 a.m., V1 stated, "We do not have an Infection Preventionist in the facility at this time. Our last Infection Preventionist quit 9/6/23."

On 9/19/23 at 10:05 a.m., V2 stated, "On 8/16/23, (V4) should have been tested for COVID-19, and not returned to work until she had two negatives with being symptomatic. (V4) should never have worked at all on 8/19 or 8/20 with being symptomatic, and we had not COVID-19 tested her. (V23) saw the two positive COVID-19 cards. We do not test agency staff on a regular basis. The agency staff would not be aware of exposure or positives until they actually came back to the building to work. I don't feel like agency is any different than visitors when it comes to exposing the residents. I don't know if they are sick when they call off, and they should be reporting to us if they are sick while they are working. No staff were day 1, day 3, or day 5 tested initially with the outbreak. The next testing date was 8/30/23. Staff that were working on A hall that day and department heads were tested. It doesn't appear all staff were tested. We initiated testing all staff on 9/7 & 9/8. There were some staff who were not tested because we cannot force them to come in on their day off. We were implementing Tuesday and Friday Testing. If the staff did not test on 9/7 or 9/8/23 we tried to capture them on their next shift. They shouldn't have worked if they didn't test. (R6) was hospitalized for

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COVID-19 pneumonia. Staff who are symptomatic have to be tested within 24 hours and then 48 hours later. After the 2nd negative, they can return to work at any point as long as they are free of a fever for over 24 hours and not requiring medication. If a staff member calls off symptomatic, we were directing them in to be tested. On 8/28/23, (V28) tested and was negative. She should have tested again in order to come back to work especially since she called off on 8/30/23. There's no documentation that she was tested again. (V29) should have been tested more than just the first time. He shouldn't have come back to work without that 2nd negative. I began testing all of the residents on 9/8/23 to ensure everyone was negative before coming out of the outbreak."

On 9/19/23 at 11:15 a.m., V1 stated, "If staff have any COVID-19 like symptoms they should be told they can't work, and they are to come into the facility to be tested within 24 hours or they can be tested at the doctors. Staff members are required to do that testing, and if it's negative, they test again 48 hours later. At this point if that test is negative and they have no symptoms, they can return to work. (V4) would have tested the initial testing on 8/17/23 and then again 48 hours later in order to come back to work both should be negative. With COVID-19 like symptoms we presume them COVID-19 positive until we get two negatives. On 8/19/23, (V4) shouldn't have even come in if she was still stick. When she came back that day, she should have let us know she was sick again in order to be tested. She should have called her supervisor and said she was sick, and she wouldn't have been allowed to work without testing. On 8/20/23, if she told (V3) she was sick, (V3) should have tested her right there and sent her home. Whether that test was

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negative or positive she would have been sent home since. (V4) should not have continued working that night. I heard that she had tested positive the following day (8/21/23), but I was being told there was no proof. We requested she come to the facility for us to test her, but she refused to come in. Since she refused to come in, we had to presume her positive. The testing should have started for the whole facility at that point. We must presume her positive back to 8/16/23 when her symptoms started. All the residents would have been affected since she worked B hall on 8/15/23 and A hall on 8/19 and 8/20/23. The staff members that she had direct contact with should have done the day 1, day 3, and day 5 contact tracing testing for sure. That should have occurred with all the residents as well. As far as I was aware, A hall and all of A hall staff were being tested, and B hall testing as well as the rest of the staff testing started on 9/8/23. From the beginning, I thought we should have just done facility wide testing to be on the safe side. I wasn't aware that all the staff, especially the contact traced staff weren't being tested. When (R3) tested positive, we should have looked back at least 24 hours and immediately tested all those staff members who took care of him. There's no excuse for that. With not testing correctly we are exposing the residents and other staff members to potentially getting COVID-19."

On 9/19/23 at 2:35 p.m., V47 (Medical Director) stated, "Symptomatic staff members should not be working while they are showing symptoms. These staff need to be tested in order to return to work. If a resident or a staff member tests positive, those who were directly exposed to that person should be tested immediately. I would prefer the whole building be tested regardless of if there is any resident or staff member who tests

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S9999	Continued From page 16 positive." The facility room roster, dated 9/11/23, documents that the facility consists of two wings (A & B) that make up the whole facility of resident rooms. The Centers for Medicare and Medicaid (CMS) Resident's Census and Condition of Residents form 672, dated 9/19/23 and signed by V2, documents that 77 residents reside in the facility. (B)	S9999		