STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0053843	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHALET LIVING & REHAB	**7350 NORTH SHERIDAN ROAD , CHICAGO, Illinois, 60626**

(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) COMPLETION DATE
S0000	Initial Comments Annual Licensure Survey	S0000		
S9999	Final Observations Statement of Licensure Violations 1 of 5: 300.615e) 300.615f) 300.615g) 300.625c)2) 300.625g) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. g) If the results of the background check are inconclusive, the facility shall initiate a fingerprint-based check, unless the fingerprint check is waived by the Director of Public Health based on verification by the facility that the resident is completely immobile or that the resident meets other	S9999		

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

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S9999	Continued from page 1 criteria related to the resident's health or lack of potential risk, such as the existence of a severe, debilitating physical, medical, or mental condition that nullifies any potential risk presented by the resident. (Section 2-201.5(b) of the Act) The facility shall arrange for a fingerprint-based background check or request a waiver from the Department within 5 days after receiving inconclusive results of a name-based background check. The fingerprint-based background check shall be conducted within 25 days after receiving the inconclusive results of the name-based check. Section 300.625 Identified Offenders c) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the following: 2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. The inquiry shall be based on the subject's name, sex, race, date of birth, fingerprint images, and other identifiers required by the Department of State Police. The inquiry shall be processed through the files of the Department of State Police and the Federal Bureau of Investigation to locate any criminal history record information that may exist regarding the subject. The Federal Bureau of Investigation shall furnish to the Department of State Police, pursuant to an inquiry under this subsection (c)(2), any criminal history record information contained in its files. g) Facilities shall maintain written documentation of compliance with Section 300.615 of this Part. This REQUIREMENT is not met as evidenced by: A. Based on record review and interview, the facility failed to obtain Criminal History Information Response Process (CHIRP) reports within 24 hours of admission for two (R12, R14) out of five (R10, R11, R13) residents. Findings include: On 9/24/25 at 9:24AM, V19 (Admission Director) stated, “I am responsible for obtaining the resident’s Criminal History Information Response Process (CHIRP) reports	S9999		

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S9999	Continued from page 2 within 24 hours of admission. If the CHIRP results in a positive HIT, then I will forward the information the Social Service Director (V11) for fingerprinting. R12 was admitted on 9/2/25, the CHIRP was not submitted until 9/8/25 and resulted in a HIT. I was off work during that time. R13 was admitted on 9/9/25 and the CHIRP results were noted 'In Process', where it remained weekly. I did make V11 aware. The CHIRP needs to be completed with 24hours of admission to ensure the safety of all residents and staff. The days I'm off work, there is no one to take on the responsibility of submitting the new admissions CHIRPs. I complete them upon my return back to work." On 9/24/25 at 9:40 AM, V11 (Social Service Director) stated, "I been working here in this position since January 2025. The admission coordinator submits the CHIRPs for the admissions and email me with any positive HITS. I then add the resident to the facility's spread sheet. I wait until I have five residents to fingerprint before I contact the fingerprint agency. Once the agency arrives at the facility then I will obtain consent. R10, R11, R12, R13, nor R14 gave consent for the fingerprints at this time, nor had fingerprints taken. I called recently, the other day, I do not remember when I called, the company will be out on October 1st. I was aware that fingerprints need to be ordered with in seventy-two hours of the positive CHIRP." Policy documents in part: Identified offender dated 6/30/25. The facility shall review the results of the criminal history background checks immediately upon receipt of the checks. The facility she be responsible for taking all steps necessary to ensure the safety of residents. If results of a resident's criminal background check reveal that the resident is an identified offender, the facility will: With in 72hours arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. B. Based on interviews and record reviews, the facility failed to arrange fingerprinting within 72 hours of the positive Criminal History Information Response Process (CHIRP) for five (R10, R11, R12, R13, R14) residents who had a positive CHIRP in a total sample of five residents. Findings include: On 9/24/25 at 9:24AM, V19 (Admission Director) stated,	S9999		

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S9999	Continued from page 3 “I am responsible for obtaining the resident’s Criminal History Information Response Process (CHIRP) reports within 24 hours of admission. If the CHIRP results in a positive HIT, then I will forward the information the Social Service Director (V11) for fingerprinting. R13 was admitted on 9/9/25 and the CHIRP results were noted ‘In Process’, where it remained weekly. I did make V11 aware. Usually, I wait until the CHIRP comes back sometimes it could take up to sixty days and inform V11 of the findings.” On 9/24/25 at 9:40 AM, V11 (Social Service Director) stated, “I been working here in this position since January 2025. The admission coordinator submits the CHIRPs for the admissions and email me with any positive HITS. I then add the resident to the facility’s spread sheet. I wait until I have five residents to fingerprint before I contact the fingerprint agency. Once the agency arrives at the facility then I will obtain consent. R10, R11, R12, R13, nor R14 gave consent for the fingerprints at this time, nor had fingerprints taken. I called recently, the other day, I do not remember when I called, the company will be out on October 1st. I was aware that fingerprints need to be ordered with in seventy-two hours of the positive CHIRP. If the CHIRP says in process, I was not sure what to do, I did not know to order the fingerprints pending the CHIRP results.” Policy documents in part: Identified offender dated 6/30/25 The facility shall review the results of the criminal history background checks immediately upon receipt of the checks. The facility she be responsible for taking all steps necessary to ensure the safety of residents. If results of a resident’s criminal background check reveal that the resident is an identified offender, the facility will: With in 72hours arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. "C" Statement of Licensure Violations 2 of 5: 300.696a) 300.696b)1)2)3)4) 300.696c)	S9999		

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S9999	Continued from page 4 300.696d)13)17) 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. 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. 1) All staff shall be trained at least annually on basic infection prevention and control practices based on job responsibilities. Training records shall be maintained for three years. For the purposes of this Section, "staff" means those individuals who work in the facility on a regular (that is, at least once a week) basis, including individuals who may not be physically in the facility for a period of time due to illness, disability, or scheduled time off, but who are expected to return to work. This also includes individuals under contract or arrangement, including hospice and dialysis staff, physical therapists, occupational therapists, mental health professionals, or volunteers, who are in the facility on a regular basis. 2) Students enrolled in accredited health care training programs who are providing direct care during internships or clinical rotations must have completed infection prevention and control training prior to working in the facility. The facility shall ensure access to documentation of completed infection prevention and control training for all interns and students and provide a copy of this record upon request by the Department.	S9999		

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S9999	Continued from page 5 3) Facility activities shall be monitored on an ongoing basis by the Infection Preventionist to ensure adherence to all infection prevention and control policies and procedures. 4) Infection prevention and control policies and procedures shall be maintained in the facility and made available upon request to facility staff, the resident and the resident's family or resident's representative, the Department, the certified local health department, and the public. c) A group, e.g., an infection prevention and control committee, quality assurance committee, or other facility entity, shall periodically, but no less than annually, review the measures and outcomes of investigations and activities to prevent and control infections, documented by written, signed, and dated minutes of the meeting. d) Each facility shall adhere to the following guidelines and toolkits of the Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, Agency for Healthcare Research and Quality, and Occupational Safety and Health Administration (see Section 300.340): 13) Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes 17) Guidelines for Environmental Infection Control in Health-Care Facilities This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure reusable equipment was cleaned and decontaminated between each use for five (R18, R19, R20, R21, R22) out of six residents reviewed for medication administration observation. Findings include: On 9/23/24 observed medication administration with V15 (Registered Nurse). On 9/23/25 at 9:16 AM, R18 after taking medications and drinking water, placed the medication and water cup	S9999		

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S9999	Continued from page 6 back onto the plastic tray, turned on its side. V15 threw out the used cups into the garbage can and places the plastic tray back on top of the medication cart and prepared R19's medications. On 9/23/25 at 9:24 AM, V15 enters R19's room, place the plastic medication tray on top R19's bed side table, once R19 was done taking medication, R19 placed the used cups back onto the plastic medication tray. V15 threw out the cups then sat the plastic medication tray back on top of the medication cart and prepared R20's medications. On 9/23/25 at 9:33 AM, V15 entered R20's room, while R20 took the medications, V15 sat the medication tray on top of R20's bed linen. V15 sat the plastic medication tray back on top the medication cart and prepared R21's medications. On 9/23/25 at 9:48 AM, after R21 took the medications, R21 placed the used cups back onto the tray. V15 threw out the cups and placed the plastic medication tray back on to the medication cart. On 9/23/25 at 9:55 AM, V15 prepared R22's medication. R22 placed her lollypop on to the plastic medication tray. After R22 took her pills, V15 placed the tray back on top of the medication cart. V15 did not sanitize the plastic medication tray between each resident or at the end of the medication pass. On 9/23/25 at 10:53 AM, V15 (Registered Nurse) stated, "I forgot to clean the medication administration plastic tray. I was focused on administering mediations. I could have spread infection from one resident to another. I should have cleaned the medication administration plastic tray with a sanitizing wipe after each use to prevent the spread of infections." On 9/2425 at 12:20 PM, V13 (Infection Preventionist) stated, "All nurses were educated to use the disposable medication trays. The nurse is to sanitize the re-usable items between residents to prevent the spread of infections." On 9/24/25 at 1:45 PM, V4 (Director of Nursing) stated, "My expectation for shared medication items with residents is for the nurses to clean and disinfect the	S9999		

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S9999	Continued from page 7 shared resident devices before and after each resident use. If the nurse does not disinfect the shared devices, that could potentially spread infection from one resident to the next resident." Policy documented in part: Medical Care Equipment, Instruments and Health IT Devices Infection Control Plan dated: 7/2/25 Reusable equipment will not be used for the care of another resident until it has been properly cleaned and reprocessed and that single use/disposable items are properly discarded after use. "C" Statement of Licensure Violations 3 of 5: 300.2100 Section 300.2100 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Code." This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to store toxic cleaning products away from food products, ensure that all food service equipment were sanitary and in working order, store/serve food in a sanitary manner, and check food temperatures at time of service. This has the potential to affect 201 of 204 residents that receive nutritional services from the kitchen. Findings include: On 9/23/2025 at 9:36 AM, surveyor conducted the initial kitchen tour with V5 (Registered Dietary Nutritionist). In the dry goods storage area, there were boxes of stainless-steel polish and degreasers on the bottom shelf near the door. They were near a rack of bread. On the bottom shelf of the perpendicular wall, there was a bottle of multi surface disinfectant cleaner. The label on the bottle warns users not to contaminate water, food or feed by storage or disposal. This bottle was next to a bin of corn flakes. At 9:51 AM, V6 (Culinary Development Specialist) stated the cleaning solutions should be stored in the facility's chemical storage	S9999		

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S9999	Continued from page 8 area. In the kitchen's stand-alone freezer, there was an open box of blueberries. Multiple blueberries were outside the plastic bag in the box. Multiple blueberries had freezer burns on them. V6 stated they were no good and facility needed to discard the entire box. At 9:58 AM, the stand-alone oven had brown and black stains to the doors. There were splatter marks to the side of the oven facing the stove. At 10:06 AM, the walk-in freezer door had ice build-up at the entry. There was ice-build up on the floor on both sides. The rubber flaps at the entrance had crystallized ice on them. The freezer's condenser had multiple areas of ice buildup underneath it and on the floor. At 10:10 AM, V8 (Dietary Aide) and V9 (Dietary Aide) were in the dishwasher room cleaning up after breakfast service. On one of the walls, there was a clipboard hanging with the dishwasher's temperature logs. There were no entries from 9/21/2025 – 9/23/2025. V8 stated the facility switched to a hot water dishwasher about two weeks ago. V8 stated the facility instructed them not to run test strips through the dishwasher anymore. V8 stated they were instructed to read the thermometer gauges outside the machine instead and to write those temperatures down on the log. V6 stated the facility must still do the test strips because the outside thermometer gauges aren't accurate sometimes. V8 brought a set of test strips but V6 stated they were no good. Facility could not locate any test strips, so V6 obtained two thermometer probes and ran it through the cycle. After the wash, one thermometer read 155F and the other read at 154F. During this observation, V9 was also taking out a tray of food covers that finished the wash and loaded them up into a cart. One of the food covers had yellow, leftover food still on it. At 12:12 PM, kitchen staff including V8 and V9 prepared the lunch trays. There were sliced fruits in 2-ounce cups that were left uncovered. During lunch observations on the third floor, CNAs (Certified Nursing Assistants) including V21 and V33 would take the lunch trays outside of the carts and carry them down the hallway with the fruit cups uncovered. On 9/24/2025 at 11:05 AM, surveyor conducted a follow-up kitchen tour. V36 (Agency Cook) placed a tray of bread rolls into the stove's oven. The bottom of the oven had multiple black, burnt food on the bottom. At 11:22 AM, V35 (Regional Director) stated that kitchen	S9999		

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S9999	Continued from page 9 staff can start with lunch service line. V36 started plating the lunch meal which included chicken, vegetable medley, and rice. Did not observe staff check the food temperatures prior to serving. V36 stated (V36) did take the temperatures and put them in the logbook. V35 and surveyor reviewed the logbook but there were no temperatures for the lunch meal. V35 instructed V36 to pause plating and check the food temperatures. The pureed chicken was at 145F (degrees Fahrenheit). V35 instructed V34 (Food Service Director) to place it in the oven. V34 placed it over the stove burner. After reheating, temperature went up to 165F. Facility's 'Consistency Census Report' documents in part that facility had three residents who do not eat by mouth (no food service from the kitchen). Facility's 'Dry Food Storage' (2/19/2025) policy documents in part: "The Dining Services Director will ensure that toxic materials are not stored with food." Facility's 'Cold Food Storage' (2/19/2025) policy documents in part: "The Dining Services Director/ Cook(s) ensures that all food items are stored properly in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination." United Stated Food and Drug Administration's Food Code 2022 documents in part that food should be protected from contamination. Facility's 'Equipment' policy documents in part: "It is the center policy that all food service equipment is clean, sanitary, and in proper working order." "The Dining Services Director will ensure that all equipment is routinely cleaned and maintained in accordance to manufacturer directions and training materials." Facility's 'High-Temperature Dish machine Temperature Log' documents in part: "Monitor and record final rinse temperature at opening and mid-day." "In order to verify the surface temperature is meeting the required temperature of 160F." Facility's 'Ware Washing of Long-Term Care Communities/CCRC' (2/19/2025) policy documents in part: "The Dining Services Director ensures that the nutrition service staff is knowledgeable in proper technique for processing dirty dish ware to clean through the dish machine and proper handling of sanitized dish ware." "The Dining Services Director ensures that all the dish machine water temperatures are maintained in accordance with manufacturer recommendations for high temperature or low temperature	S9999		

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S9999	Continued from page 10 machines." "The Dining Services Director is responsible for insuring appropriate completion of temperature and/or sanitizer concentration logs as appropriate." Facility's 'Food: Preparation' (10/2019) documents in part that poultry foods will be heated to 165F. "Temperature for Time/Temperature Control for Safety (TCS) foods recorded at time of service and monitored periodically during meal service periods as indicated." "C" Statement of Licensure Violations 4 of 5:300.661 Section 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the Department of Correction Inmate search was time stamped for seven employees, ensure the Checked Registry, Checked Fee Application and Eligible to work was completed before the start of employment for one employee and ensure the Illinois Department of Professional Regulation check was completed before the date of hire for one employee. These failures have the potential to affect all the residents residing in the facility. Findings include: On 09/23/25 at 09:32 AM surveyor spoke with V14 (Human Resources) via telephone regarding the healthcare workers background checks. On 09/23/25 at 03:15 PM During review of the healthcare workers background check with V10 (Administrator from Sister Facility); V24 (Certified Nursing Assistant/CNA), V25 (CNA), V26 (CNA), V27 (CNA), V28 (Activity aide) V29 (CNA), V11 (Social Service Director) had no time stamped documentation for the Department of Correction Inmate search. V27 (CNA) has a hire date of 01/30/25 with a Checked Registry, Checked Fee Application and Eligible to work dated 01/31/25, date completed after the hire date. V30 (Licensed Practical Nurse) has a hire date of 12/24/2025 with an Illinois Department of Professional Regulation check dated 01/02/25, date completed after the hire date. V10	S9999		

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S9999	Continued from page 11 (Administrator from Sister Facility) stated the Department of Corrections (DOC) use different browsers, and it should be time stamped. This (referring to the DOC document) is it; I just don't see the date on there. There are no time stamps for the DOC inmate searches V27 (CNA) registry check, fee app and eligible to work is dated 01/31/25. V27 was hired on 01/30/25. V30 (Licensed Practical Nurse) Illinois Department of Professional Regulation check dated 01/02/25 after the date of hire o 12/24/24. Document titled "Job Description Human Resource Director" dated 03/04/22 document in part: The Human Resource Director directs the Human Resource Department in accordance with current applicable federal, state and local standard, guidelines, and regulations, to assure that quality personnel are interviewed, trained and employed. 7. Check applications and references of prospective employees and arrange for interview with human resources and/or department directors as required or requested. 8. Maintain job applications for personnel eligible to work in the facility utilizing electronic applicant tracking system. 21. Conduct and Ensure employee hiring, vetting, and discharge procedures are in compliance with federal, state, and local regulations and facility established policies and procedures. Policy: Titled "Abuse and Neglect" revised 06/26/25 document in part: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. These guidelines include compliance with the seven (7) federal components of prevention and investigation. 7 Steps of Abuse Prevention: The seven elements of prevention and investigation include: Screening, Training, Prevention, Identification, Investigation, Protection and Reporting Response. I. Screening: Have procedures to: Screen potential employees for a history of abuse, neglect, exploitation, misappropriation of property, or mistreating residents. This includes attempting to obtain information from previous employers and/or current employers and checking with the appropriate licensing boards and registries. Prior to placement in the facility, the facility will require background check of prospective consultants, contractors, volunteers, caregivers working on behalf of the facility. "C"	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0053843	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHALET LIVING & REHAB	**7350 NORTH SHERIDAN ROAD , CHICAGO, Illinois, 60626**

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S9999	Continued from page 12 Statement of Licensure Violations 5 of 5: 300.1060e) 300.1060f) 300.1060g) Section 300.1060 Vaccinations e) A facility shall distribute educational information provided by the Department on all vaccines recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (available at: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf), including, but not limited to the risks associated with shingles and how to protect oneself against the varicella-zoster virus. The facility shall provide the information to each resident who requests the information and each newly admitted resident. The facility may distribute the information to residents electronically. (Section 2-213(e) of the Act) f) A facility shall document in the resident's medical record that he or she was verbally screened for risk factors associated with hepatitis B, hepatitis C, and HIV, and whether or not the resident was immunized against hepatitis B. (Section 2-213(c) of the Act) g) All persons determined to be susceptible to the hepatitis B virus shall be offered immunization within 10 days after admission to any nursing facility. (Section 2-213(c) of the Act) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that they educated residents and their representatives regarding the risks associated with shingles and how to protect the residents against the varicella-zoster virus, failed to screen and document risk factors associated with hepatitis B, hepatitis C, and Human Immunodeficiency Virus (HIV), and failed to offer immunization within ten days after admission for residents who are susceptible to hepatitis B for five (R2, R4, R15, R16, R17) out of five residents reviewed for immunizations. Findings Include:	S9999		

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S9999	Continued from page 13 On 09/23/25 at 09:28 AM V13 (Infection Preventionist) stated “We offer the hepatitis B vaccination to the staff on hire, but we do not screen or offer it to the residents. We offer the shingles vaccination to residents on admission. We get the HIV information (status) of the residents from the hospital if they are HIV positive, but we do not screen them. If there is something we suspect, we may do some lab work.” On 09/24/25 at 12:06 PM V4 (Director of Nursing) stated “the pneumococcal vaccination recommendation is for the facility to offer it to the resident upon admission in the facility. If the resident can consent, you can ask if they want it.” Review of (R2, R4, R15, R16, R17) there is no documented screening of Shingles, hepatitis B, hepatitis C, and Human Immunodeficiency Virus (HIV) on the Immunization Audit Report or the electronic medical records. Policy: Titled “Shingles Care Guidelines” dated 02/22/25 document in part: The facility will follow guideline on the administration of the shingles vaccine to eligible residents and promote public health by reducing the risk of shingles and its complications. This guideline outlines the eligibility, administration, and requirements regarding the shingles vaccine for residents aged 50 years and older, as well as those with certain medical conditions as recommended by CDC (Centers for Disease Control). The facility will provide Shingle information to each resident who requests the information and each newly admitted resident. 1. Individuals 50 and polder are recommended to receive the shingles vaccine. 1. All individuals receiving the shingles vaccine will have their vaccinations documented in electronic medical record under the immunization tab. Titled “HIV and Hep B and C Screening Guidelines” dated 02/25 document in part: This guideline provides protocols for screening residents for HIV (Human Immunodeficiency Virus) and Hepatitis (Hep B and C) to identify risk and to ensure early detection and treatment and to prevent transmission and improve health outcomes. All residents admitted to the facility shall be verbally screened for risk factors associated with hepatitis B, Hepatitis C and HIV, and documentation of the screening is in the admission section of every admission UDA (User-Defined Assessment). The screening can also be performed upon resident’s and MD’s (Medical Doctor) request.	S9999		

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S9999	Continued from page 14 Individuals identified at risk for Hep B and C and HIV shall be offered to be tested, if they are going to be admitted to the facility for at least 7 days. Individuals identified as susceptible to Hep B will be offered immunization within 10 days of facility admission. Documentation of testing and Hep B vaccine offering or refusing shall be documented in the resident's progress notes. "C"	S9999		