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S 000	Initial Comments Complaint Investigations 2317372/IL164032 and 2317386/IL164043	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.696 b) 300.696 d)6) 300.696 f)2)A) 300.696 f)4) 300.1210 b) 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 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	S9999	Attachment A Statement of Licensure Violations	

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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.

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):

6) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings

f) Infectious Disease Surveillance Testing and Outbreak Response

2) Each facility shall conduct testing of residents and staff for the control or detection of infectious diseases when:

A) The facility is experiencing an outbreak;

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.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary

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S9999	Continued From page 2 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 resident to meet the total nursing and personal care needs of the resident. These requirements are not met as evidenced by: Based on observation, interview, and record review facility, failed to ensure sure staff doffed PPE (personal protective equipment) in a manner to prevent cross-contamination after caring for COVID-19 positive residents; failed to ensure residents were not exposed to staff exhibiting symptoms of COVID-19; failed to implement transmission-based precautions for residents exhibiting symptoms of COVID-19; failed to have a system in place to accurately track/trend resident and staff exposures to COVID-19 during a facility outbreak; failed to have an effective system in place to test staff and residents for COVID-19 during a facility outbreak; and failed to ensure COVID negative residents were not exposed to COVID positive residents. These failures resulted in a facility outbreak of COVID-19 which, as of 9/11/23, included twenty-eight positive residents and fourteen positive staff. Three of the twenty-eight residents were hospitalized for COVID. These failures have the potential to affect all 72 residents residing in the "A" Building of the facility. The findings include:	S9999		

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A facility roster, dated 9/11/23, showed a census of 72 residents in the "A" Building.

A facility map, dated 9/11/23, showed the "A" Building was divided into 4 wings which included A-North, A-South, A-East, and A-West.

A facility resident/staff COVID-19 report, printed 9/11/23, showed the COVID-19 outbreak started on 8/24/23, when a staff member tested positive. The report showed by 9/3/23, the COVID outbreak had spread to residents on the A-West, A-South, and A-North wings of the "A" Building. By 9/8/23, twenty-eight residents had tested positive for COVID. All twenty-eight residents resided in the "A" Building. Fourteen staff had tested positive. Of those fourteen staff members, thirteen of them worked in the "A" Building. As of 9/8/23, three residents (R13-R15) had been hospitalized due to COVID.

1. R7's Health Status Note, dated 9/4/23, showed R7 had tested positive for COVID-19. R7 was placed on droplet/contact isolation (transmission-based precautions) for ten days. On 9/11/23 at 10:41 AM, V3 Assistant Director of Nursing (ADON) exited R7's room, after providing cares to R7, without doffing her contaminated N95 mask or plastic face shield. V3 walked over to a PPE cart in the hallway, removed her face shield, and placed the contaminated face shield in the top drawer of the cart, on top of a box of gloves and N95 masks. At no time did R7 remove her contaminated N95 mask.

R9's Physician Order, dated 9/3/23, showed R9 was placed on droplet/contact isolation, for ten days, after testing positive for COVID.
On 9/11/23 at 10:48 AM, V4 and V5, CNA's

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(Certified Nursing Assistants), exited R9's room. V4, CNA, exited the room without removing her contaminated N95 mask. V5, CNA, exited the room without removing her contaminated N95 mask, or disinfecting the face shield she wore in R9's room.

R10's Physician Order, dated 9/6/23, showed R10 was placed on droplet/contact isolation, for ten days, after testing positive for COVID.
On 9/11/23 at 11:06 AM, V8, Registered Nurse, donned PPE and entered R10's to administer medications to R10. At 11:08 AM, V8 exited R10's room without doffing her contaminated N95 mask or disinfecting her face shield. V8 then pushed her medication cart down to the nurses station, while wearing the contaminated PPE.

On 9/12/23 at 7:35 AM, V2, Director of Nursing (DON), stated, "Staff must remove and discard their N95 masks, before exiting a COVID positive room. Staff must disinfect their face shields prior to exiting a COVID positive room to attempt to prevent the spread of COVID-19."

The facility's Standard Precautions/Transmission-Based Precautions policy (undated) showed staff are to remove and discard all PPE (gloves, gown, mask, and eye protection) prior to exiting the room of a resident on any transmission-based precautions.

2. The facility's nursing schedule, dated 8/24/23, showed V13, CNA, worked from 11:00 PM on 8/24/23 until 7:00 AM on 8/25/23 on the A-South wing.
V13, CNA's, urgent care discharge report, dated 8/26/23, showed V13 tested positive for COVID-19.

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On 9/12/23 at 10:51 AM, V13, CNA, stated she developed a sore throat while working the night shift on 8/24/23. V13 stated, "I noticed my throat was sore towards the end of my shift. I was tired by didn't think much of it. I didn't report my symptoms to anyone. Later that day (on 8/25/23), I started to feel worse and had a fever. I went and got tested for COVID. I was positive." V13, CNA, stated on 8/24/23, she provided cares to residents on the A-South wing, which included incontinence care, toileting, and transferring residents out of bed. V13 stated she did not wear a mask while providing cares to residents during her shift.

On 9/11/23 at 12:48 PM, V9, Infection Preventionist (IP)/RN, stated V13, CNA, failed to report to facility management, that she had developed a sore throat and fatigue "towards the end of her shift" on the morning of 8/25/23. V9 stated V13 finished her shift and left the facility without being tested for COVID, or reporting her symptoms. V9 stated she was notified of V13's positive COVID test on 8/26/23. V9 stated, "If staff become sick at work, they should notify their supervisor immediately, get tested for COVID, and immediately be removed from resident care to avoid potentially exposing residents to COVID." When V9 was asked if she had tested the residents V13, CNA, had provided cares to on 8/24/23-8/25/23, V9 stated, "I took the contact tracing approach. I didn't feel (V13, CNA) had really any close contact to any residents during her shift, so I didn't test anyone."

The facility's COVID-19 Testing Plan and Strategy policy, dated 5/25/23, showed, "Any resident or HCP (healthcare professional) who develops fever or symptoms consistent with COVID-19, regardless of vaccination status, should receive a

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COVID test as soon as possible."

3. R1's Health Status Note, dated 9/2/23, showed R1 had developed complaints of nausea and had one episode of vomiting. R1 was COVID tested, which showed a negative result.
R1's Administrative Note, dated 9/3/23, showed R1 had developed "generalized" congestion. The note showed no documentation R1 was retested for COVID, or placed on isolation.
R1's Health Status Note, dated 9/4/23, showed R1 tested positive for COVID, and was placed on isolation at that time.
On 9/11/23 at 11:03 AM, V7, CNA, stated she felt facility administration "didn't act quick enough" to try to stop the COVID outbreak. V7 stated, "I took care of (R1) on September 3rd and 4th (2023). I reported to her nurse, both days, that I didn't think (R1) felt well. (R1) was pale, not eating, and tired. She had a cough. I know they didn't test her on September 3rd. She also wasn't on isolation on September 3rd."
On 9/12/23 at 8:26 AM, V15, RN, stated she cared for R1 on 9/3/23. V15 stated, "(R1) had generalized congestion, which I medicated her for. I did not retest her for COVID or put her on isolation at that time."
A physician order for R1, dated 9/4/23, showed R1 was not placed on droplet/contact isolation until two days after developing COVID symptoms.

R2's Health Status Note, dated 8/30/23, showed R2 developed a new onset of fever. The note showed R2 tested negative for COVID. The note showed no documentation R2 was placed on isolation at that time.
R2's Health Status Notes, dated 8/31/23, showed R2 continued to have a fever. The notes showed no documentation R2 was retested for COVID.
R2's Health Status Note, dated 9/1/23, showed

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R2 appeared lethargic with continued fevers. R2 had developed a slight cough. R2 tested positive for COVID, and was placed on isolation at that time.
A physician order for R2, dated 9/1/23, showed R2 was not placed on droplet/contact isolation until two days after developing COVID symptoms.

R3's Plan of Care notes, dated 9/1/23, showed R3 had developed "cold symptoms and fatigue." The notes showed R3 required supplemental oxygen to keep her oxygen level within normal limits. R3 was tested for COVID, which showed a negative result. The notes showed no documentation R3 was placed on isolation at that time.
R3's Health Status Note, dated 9/3/23, showed R3 still required supplemental oxygen. The note showed R3 had been started on an antibiotic, for treatment of pneumonia. The note showed R3's daughter had taken R3 outside for a visit.
R3's COVID test results and Health Status Notes, dated 9/4/23, showed R3 tested positive for COVID, and was placed on isolation at that time (three days after developing symptoms).

On 9/12/23 at 11:20 AM, V17, Communicable Disease (CD) Coordinator for the local health department stated, "Any resident that has been exposed to COVID and develops symptoms must be placed on droplet/contact isolation immediately, even if their initial COVID test is negative. They are to remain on isolation for 5 days. They can come off isolation if they no longer have symptoms and their day 1, day 3, and day 5 COVID tests are negative."

The facility's Infection Control COVID-19 policy, dated 5/25/23, showed, "Monitoring residents for fever or symptoms, such as shortness of breath,

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new or change in cough, and sore throat; and asking residents to report if they feel feverish and have symptoms of respiratory infection. If symptoms are identified, move to action steps to prevent the spread of respiratory germs within the campus to include restricting residents with fever or acute respiratory symptoms to their room ..."

4. V19's (Respiratory Therapist) Time Clock Report, dated 9/1/23, showed V19 worked 8:15 AM-4:30 PM in the "A" Building.
The facility's COVID-19 tracking report, dated 9/1/23, showed V19 tested positive for COVID on the evening of 9/1/23 after he began feeling "off."

V18's (Dietary Aide) Time Care report, dated 8/30/23, showed V18 worked as a dietary aide in the "A" Building from 4:31 PM-7:40 PM.
The facility's COVID-19 tracking report, dated 9/1/23, showed V18 tested positive for COVID on 8/31/23.

The facility's nursing schedule, dated 8/31/23, showed V21, CNA, worked on the A-North wing from 6:00 AM-3:00 PM.
V21's COVID test, dated 9/1/23, showed V21 tested positive for COVID.

On 9/12/23 at 10:15 AM, V9, IP/RN, stated she did not complete any contact tracing to track/trace which residents or staff had potentially been exposed to COVID by V18, V19, or V21. V9 stated, "When the COVID outbreak started, we only had one positive staff member, so I decided to take the contact tracing/testing approach to the outbreak. As the outbreak got worse, I continued to use the contact tracing method to track potential exposures caused by our positive residents, but I didn't track the potential exposures our positive staff may have caused. I

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didn't know contact tracing included tracking exposures created by our positive staff." When V9 was asked why she did not change to the broad-based tracing/testing approach when the facility's COVID outbreak had spread to three of the four wings in the "A" Building (by 9/3/23), V9 stated, "I thought it was ok for me to continue with the contact tracing. It just spread so fast. It was chaos." V9 stated she did not begin broad-based COVID testing for residents, in the "A" Building, until 9/7/23. Broad-based testing for staff, in the "A" Building, was not started until 9/11/23.

On 9/12/23 at 11:20 AM, V17, Communicable Disease (CD) Coordinator for the local health department, stated, "Contract tracing/testing for COVID is only effective if facilities contract trace potential exposures caused by both, positive residents and positive staff. We had told (V9 IP/RN), multiple times, that she was to stop using the contact tracing approach for their outbreak, and start the broad-based approach. (V16, CD Staff) spoke with (V9) on 9/1/23 and told her to switch to broad-based testing. (V12, CD Staff) spoke with (V9) again on 9/5/23 and told her to start doing the broad-based testing immediately. We told (V9) the contact tracing approach is ok to use if the outbreak is contained to 1-2 residents on the same hallway or wing. If multiple residents start turning positive per day, or the outbreak spreads to other hallways/wings, they must change to the broad-based approach."

The facility's COVID-19 Testing Plan and Strategy policy, dated 5/25/23, showed one confirmed COVID-19 case, resident or staff, triggered an outbreak investigation. The policy showed the facility should considered a broad-based approach to an outbreak "if additional cases are identified from testing close contacts or

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higher-risk exposures, facilities should expand testing as determined by the distribution and number of cases throughout the facility and ability to identify close contacts ..."

5. On 9/11/23 at 11:03 AM, R4 was seated in a wheelchair, by the nurses station, on the unit of the COVID outbreak. R4 wore a surgical mask, down under her chin, with her mouth and nose exposed.

On 9/11/23 at 11:44 AM, R5 was seated in a reclined wheelchair, in the hallway, outside of COVID positive rooms (rooms 270, 271). The doors to rooms 270 and 271 were wide open. No mask was noted on R5.

On 9/12/23 at 7:35 AM, V2, DON, stated, "The doors to rooms of COVID positive residents should be closed, unless the residents are a fall risk. If a resident is COVID negative, the resident can come out of their room, but they must have a surgical mask on."

On 9/12/23 at 9:03 AM, V14, Nurse Practitioner, for R1-R3 stated, "The expectation is that the facility is following the IDPH (Illinois Department of Public Health) guidelines for COVID and is putting measures in place to stop the spread of COVID in the facility."

(A)