STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6009427	B. WING		12/10	0/2020
	PROVIDER OR SUPPLIER	ARE CENTER HIGHWAY	DRESS, CITY, 17 EAST IL 61483	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000		1	
54	Complaint investiga 2029233/IL128938					
	Focused Survey wa	n Control Survey/COVID-19 as conducted by Illinois ic Health on December 10,		7.6 		
	Survey Census: 76					
	Total Sample: 37					
S9999	Final Observations		S9999	/2002		
	Statement of Licens	sure Violations		<del>Ida</del>		
	300.610a) 300.696a) 300.696c)2)6)7) 300.1020a) 300.3240a)					8.4
а	Section 300.610 Re	esident Care Policies	i.			
	procedures governing facility. The written be formulated by a land Committee consisting administrator, the admedical advisory coof nursing and other policies shall comply	dvisory physician or the mmittee, and representatives services in the facility. The with the Act and this Part.				E
	the facility and shall	shall be followed in operating be reviewed at least annually ocumented by written, signed of the meeting.		Attachment A Statement of Licensure Violations	1	

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

(X3) DATE SURVEY

Illinois Department of Public Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:			COMPLETED	
		IL6009427	B. WING		12/1	0/2020
	PROVIDER OR SUPPLIER	HIGHWAY	17 EAST	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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	controlling, and preshall be established and procedures shall include the requirer Communicable Disc 690) and Control of Diseases Code (77 Activities shall be molicies and proced c) Each facility guidelines of the Cocenters for Diseases United States Public of Health and Huma 300.340):  2) Guideling Health-Care Setting 6) Guideling Health-Care Setting 7) Guideling Health Care Person Section 300.1020 (Policies  a) The facility of Communicable Discode 690).  Section 300.3240 An owner, li	Infection Control If procedures for investigating, venting infections in the facility of and followed. The policies all be consistent with and ments of the Control of eases Code (77 III. Adm. Code Sexually Transmissible III. Adm. Code 693). Inonitored to ensure that these tures are followed. If shall adhere to the following enter for Infectious Diseases, a Control and Prevention, and Prevention, and Services (see Section enter for Infection Control in the for Infection Contro	\$9999			

(X2) MULTIPLE CONSTRUCTION

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FOR	O, OOTALEONON	BERTH TOXITOTHORDER	A. BUILDING:			
		IL6009427	B. WING		12/1	0/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
TOULON	REHAB & HEALTH C	CARE CENTER HIGHWAY TOULON,				·
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	E ACTION SHOULD BE COMPLETE O TO THE APPROPRIATE DATE	
\$9999	Continued From pa	ge 2	S9999		-	·
:	neglect a resident.	(Section 2-107 of the Act)				
	These regulations v	were not met as evidenced by:				
	review, the facility for Disease Control guidance and the faprevent the potential contagious disease having dedicated strongirmed COVID-1 staff members to wisolation precaution isolation precaution PPE (Personal Properforming proper I changes, not allowing sanitizing/disinfecting contames.)	to residents and staff by not taff to care for residents with 19 and allowing symptomatic ork, not posting designated as signage for residents on as/units, not don/doffing proper tective Equipment), not mand hygiene and glove and adequate contact times for any surfaces and not ainated dietary equipment prior his has the potential to affect				
	Findings include:				ē.	
	policy, dated 8/25/2 within the facility to care for residents was pace should be phrooms that house recovide and covide	will be assigned to work only d area, when in use."				а
<u>.</u>	dated 10/1/20, doci	D-19 Control Measures policy, uments, "All staff is to perform n exiting a residents' room,				

(X3) DATE SURVEY

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		IL6009427	B. WING		12/1	0/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TOULON	REHAB & HEALTH C	CARE CENTER HIGHWAY TOULON,				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	OULD BE COMPLETE	
S9999	Continued From page 3		S9999			
	contaminated surfa Contact precautions Implement when a having any fever, re throat, nausea, von fatigue, muscle pair	with residents or potentially ces (high touch areas). s: Post Signage on door: resident is suspected of espiratory symptoms, sore niting, diarrhea, extremen, loss of taste and/or smell.				
	with respiratory sec surfaces. Wear a g potentially come int	there is a potential for contact retions or contaminated own if clothing could o contact with respiratory ble contaminated surfaces.	33			
	Change gloves and resident and performand hygiene before	gowns after contact with a m hand hygiene. Perform e and after touching the environment and/or residents				
Fa	respiratory secretio Remove PPE (Pers when leaving a resi alcohol-based hand	ns even if gloves are worn. conal Protective Equipment) dent's room. Use an I rub for routinely				
3	visibly contaminate non-dedicated, non equipment after each	ands, when hands are not d. Clean and disinfect -disposable resident care ch use." The policy also et Precautions: Post signage		÷		
	of having any fever, throat, nausea, von fatigue, muscle pair Restrict all resident symptoms, sore thr	when a resident is suspected, respiratory symptoms, sore niting, diarrhea, extreme n, loss of taste and/or smell. s with fever, respiratory oat, nausea, vomiting,			94	
ě.	taste/smell to their in residents in a private gloves, gown, goggentering room or where idents on drople when leaving residents. Clean and	atigue, muscle pain, loss of room. Place symptomatic te room. Wear facemask/N95, les, or face shields when nen working within six feet of the precautions. Remove PPE ents' room and perform hand disinfect non-dedicated, ident care equipment after				

(X2) MULTIPLE CONSTRUCTION

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING IL6009427 12/10/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **HIGHWAY 17 EAST** TOULON REHAB & HEALTH CARE CENTER **TOULON, IL 61483** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 Continued From page 4 S9999 each use." The CDC's Responding to COVID-19: Considerations for the Public Health Response to COVID-19 in Nursing homes, dated 4/30/20, documents, "Assign dedicated HCP to work only on the COVID-19 care unit. At a minimum, this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. HCP working on the COVID-19 care unit should ideally have a restroom, break room, and work area that are separate from HCP working in other areas of the facility. This form also documents, "Place signage at the entrance to the COVID-19 care unit that instructs HCP they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms." The facility's Employee, Vendor, Consultant COVID Screening Questionnaire, dated 6/3/20, documents, "Please complete upon entrance to the facility and give to the Nurse/DON (Director of Nursing). In an effort to protect our residents and staff from illness, we are screening all employees, vendors, surveyors, Ombudsman, and consultants. Subsequent evaluation should be completed every four hours while in attendance of residents. Proper hand hygiene and appropriate use of PPE is expected upon entrance to the facility and while in the facility." The questionnaire also documents, "Physical Evaluation: After recording temperature, please also note yes or no to the presence of the listed symptoms below. If you mark yes to any new onset of a symptom below you are to be evaluated by a nurse. While at work, if you develop any new symptoms that

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includes cough, shortness of breath, fever, etc,

Illimois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: IL6009427 B. WING 12/10/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **HIGHWAY 17 EAST TOULON REHAB & HEALTH CARE CENTER TOULON, IL 61483** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) S9999 Continued From page 5 S9999 immediately stop direct resident care, perform hand hygiene, put on a surgical mask, notify your supervisor and wait for instructions. If a new symptom develops at home, stay at home, self isolate, follow the Local Health Department's instructions, and notify your supervisor you are not coming to work." The symptoms listed on the questionnaire to answer yes or no to are the following: New or worsening cough, sore throat. chills or shaking with chills, muscle pain, headache, new loss of taste or smell, any new onset of shortness of breath, any new or worsening fatigue, runny nose or nasal drainage, gastrointestinal upset (vomiting or diarrhea). The facility's COVID-19 Control Measures, dated 10/1/20, documents, "Restrictions for Health Care Personnel: Educated all employees if having symptoms of a respiratory infection, fever, sore throat, nausea, vomiting, diarrhea, extreme fatigue, muscle pain, loss of taste and/or smell not report to work and to contact their regular provider. Initiate screening at entryway of facility for symptoms of COVID-19 and/or fever." The facility's Crisis Staffing for COVID-19 policy, dated 5/17/20, documents, "Educate all employees if having symptoms of a respiratory infection, fever, sore throat, nausea, vomiting, diarrhea, or extreme fatigue not to report to work and to contact their regular provider. Screen all employees prior to the beginning of the shift and middle of the shift. If any are identified as being ill, apply facemask, and ask them to return home and contact their primary physician. Suspected or diagnosed COVID-19 in Long term care facility of any employee that is symptomatic will not be allowed to work until meets criteria."

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The facility's Cleaning & Transporting of Food

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6009427	B. WING		12/10/2020	
	PROVIDER OR SUPPLIER	HIGHWAY	17 EAST	STATE, ZIP CODE		
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\$9999	12/7/18, documents transporting and cleand to prevent the and to prevent the about the fact that a touch object such a faucet handles, the have some sort of touching your eyes foods after touching your have had time. The policy also doc for the facility's hyd 30 seconds, and the disinfectant is one. The facility Designa COVID-19 Outbread documents, "Red zo been tested and cover yellow zone: Designated area for exposure to COVID. The facility floor plate (Administrator) on A, C, and D hall are been exposed to C are they symptomatic, exposite that the strength of the presidents (red zone symptomatic, exposite that the strength of the strength of the symptomatic, exposite that the strength of the str	in Isolation policy, dated s, "Policy: To ensure proper eaning of resident food trays spread of microorganisms."  policy, no date, documents, ch areas frequently. Think every time you touch a high as a door handle or even the are is a good change you now germ on your hands. Avoid anose and mouth, or eating gothis high touch objects until to properly wash your hands. Examents that the contact time are germicidal bleach minute."  ated Zones During a sk policy, no date available, cone: For residents who have confirmed to have COVID-19.  nated area for residents who have confirmed to have COVID-19.  and the for residents who have not covided by V1 11/28/20, documents that the eall residents who have not covidents who have not covidents are generally by a roommate nor attic (green zone). B Hall is split to that the general process of the property of the policy of the policy.  And the front half are sed by a roommate, and new gegative for COVID-19 (yellow also a COVID positive also a COVID positive	S9999			

**RY1Y11** 

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AID I MI	o, sorting	SETTI TOTALION HOMELA	a. Building:	A. BUILDING:		<u></u>
		IL6009427	B. WING		12/10/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		74
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IOOLON	KENAD OLNEALIN	TOULON,	IL 61483			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	age 7	S9999			
	On 11/28/20 at 9:00 a.m., the facility's designated entrance was located on the end of their D hall.  No staff members were dedicated to monitoring the facility's entrance.			50		
	11/28/20, document for the day: 1st (6:0 shift (2:00 p.m. to 1 assigned to work b p.m. to 6:00 a.m.) both A & B hall, and work both C, D and	assignment sheet, dated ats the following assignments 00 a.m. to 2:00 p.m.) and 2nd 10:00 p.m.) one nurse is oth A & B hall; 3rd shift (10:00 one nurse is assigned to work d one nurse is assigned to d E hall. The facility's daily a dated 11/16/20 to 12/2/20, e assignments.	3			Ť.
	cleaning the dining stated that she is of half today as well at V4 also stated, "I dhigh contact surfact and halfway railing a.m. to 2:00 p.m. I wipes or the hydrog spray. I don't know Then, V4 stated, "I COVID-19) when y temperature and fill No one is at the do	O a.m., V4 (Housekeeper) was room following breakfast, V4 deaning the front lobby and D as helping with the dining room. On't know what you mean by ses. I clean the door handles once on my shift. I work 6:30 use the bleach disinfectant gen peroxide disinfectant what the contact times are." We are screened (for we get to work. I take my own II out the questionnaire myself. For when we come in. After four emperature myself again."		=		gi
Illinois Depa	mopping the dining stated that she is v as in the dining roo high contact surfac the bleach disinfect the contact time is	5 a.m., V5 (Housekeeper) was a room after breakfast, and working A & C hall today as well om. V5 also stated, "I clean the ses once or twice per shift with stant wipes. I don't know what "Then, V5 stated, "I screen to work by checking my				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6009427	B. WING		12/1	10/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TOULON	REHAB & HEALTH C	ARE CENTER HIGHWAY				
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S9999	Continued From pa	ge 8	S9999			
	again four hours lat			었		
	Nurse-LPN) was sit station with another she was working C screens myself by t filling out the questi and again four hour receptionist at this telse comes into the member goes and a the COVID screenir nurse that works be sitting there at the chall is COVID positi Nursing Assistant) is CNA works A Hall, a quarantine (yellow positive CNA norma but the other two CI she needs help with CNA (V20) who is we COVID positive here positive at the begin hall. She continued but she hasn't been	is a.m., V6 (Licensed Practical ting at the central nurses' nurse V7 (LPN). V6 stated & D halls today. V6 stated, "I aking my temperature and onnaire when I get to work is later. We do not have a time. If a visitor or someone facility, an available staff answers the door and does ng." V6 also stated, "One oth A and B. That is her (V7) lesk. The back portion of B ve. One CNA (Certified is dedicated to back there, one and the third CNA works the portion) of B hall. The COVID ally stays behind the curtain, NAs go back there to help if it is a two assist resident. The vorking back there right now is self. V22 (CNA) also tested aning of her shift back on E working the rest of her shift, back since that day. That is really starting getting worse.				
	On 11/28/20 at 10:0 standing in the hally equipment, V8 state D halls (green) toda the vitals equipment the bleach disinfection the contact time is."	200 a.m., V8 (CNA) was vay holding the vitals and that she was working C and by. V8 also stated, "I disinfect that after each residents. I use ing wipes. I don't know what then, V8 stated, "Staff from halls are able to come into	<i>(</i> *			

PRINTED: 01/26/2021 **FORM APPROVED** Illimois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: IL6009427 B. WING 12/10/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **HIGHWAY 17 EAST TOULON REHAB & HEALTH CARE CENTER TOULON, IL 61483 SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION ID  $\{X5\}$ (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 9 S9999 On 11/28/20 at 10:05 a.m., the E Hall double doors opened. A staff member pushed an enclosed food cart out into D hallway and left it. At 10:15 a.m., V10 (Dietary Cook) wheeled the food cart up the D hall, past the nurses' desk, and into the dining room stopping at the window of the dishwasher in the dining room. V10 opened the food cart. The food cart contained multiple hard plastic trays, with a disposable food container. plastic cups/mugs, and silverware on each one. V10 confirmed that this cart was from the COVID positive E hall and that it is not disinfected before she takes it throughout the facility to the dining room. On 11/28/20 at 10:40 a.m., B Hall yellow zone: exposed/symptomatic/COVID negative quarantine rooms. B1-B4 and B12-B16 all had stop signs only on door. No specific isolation precautions were posted. A plastic curtain was hanging midway down the hallway starting at room B5 to separate the red zone from the yellow zone. The other side of the curtain was the COVID positive residents. The plastic curtain only

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contained a stop sign, no isolation precautions were posted nor designation that this was a

On 11/28/20 at 11:20 a.m., V13 (CNA) was working the vellow side of B hall, V13 entered R5's room with a gown, N95 mask covered by a surgical mask, goggles, and gloves on. At 11:25 a.m., V13 exited the room wearing the same gown and gloves. Then, V13 entered R6's room. with the same gown and gloves on, exited that room and entered R7's room, V13 exited R7's room with no gloves, but still with the same gown. Then, V13 entered room R8's room, still with the same gown on and no gloves. Without applying

COVID positive zone.

PRINTED: 01/26/2021 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: \_ COMPLETED B. WING IL6009427 12/10/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **HIGHWAY 17 EAST TOULON REHAB & HEALTH CARE CENTER TOULON, IL 61483** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 10 S9999 gloves or a new gown, V13 picked up R8's glass of water on R8's bed side table, and assisted R8 with taking a drink of water. V13 set the glass back on the bed side table, and without performing hand hygiene or changing her gown, V13 exited R8's room, and walked to the central nurses' station, touching her hair and face multiple times. On 11/28/20 at 11:35 a.m., R6 had a loose non productive cough audible from the hallway On 11/28/20 at 11:55 a.m., V13 stated, "All of the residents that I am taking care of are on quarantine and isolation. The doors do not have specific isolation precautions posted on the doors nor does the COVID-19 curtain separating this hall. I don't know what the specific isolations are for each resident. I just know I have to wear a new gown and gloves with each room I enter. I wear the same gown out in the hallways. I have to change into another one as soon as I go into the rooms." V13 also stated that the nurse caring for B hall also works A hall all the time.

On 11/28/20 at 11:45 a.m. V14 (Housekeeping/Laundry Supervisor) stated, "We use bleach germicidal wipes and spray, and hydrogen peroxide disinfectant spray to clean/disinfect. Both have a contact time of 30 seconds to one minute. Our high contact surfaces are supposed to be cleaned every two hours. Today, V23 (Housekeeper) is working the COVID positive hallways. She starts with the yellow side of B hall, then the COVID positive side of B hall. and she finishes on E hall. She takes her cleaning cart throughout the facility."

On 11/28/20 at 12:10 p.m., V15 (Registered Nurse) was passing medications to residents on A Illinois Department of Public Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		IL6009427	B. WING		12/1	0/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
TOULON	I REHAB & HEALTH O	ARE CENTER HIGHWAY TOULON,				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	left at 10:00 a.m., a and the B hall. A ha not tested positive, residents who are of symptomatic or have back side of B hall is residents. The med positive residents is medication room by prepare one resider and administer the my cart. I repeat this the medications on quarantine rooms (yield wash my hands entering the room a wear the same gow unless its needed si	e took over for V7 when she nd is now working the A hall II is the residents who have the front side of B hall is the on quarantine for being the been exposed, and the sthe COVID positive ication cart for the COVID	S9999			
	cart was located ins curtain, with meal tr On 11/28/20 at 12:3 am working the CO nurse that works bathe rest of B hall anresidents that I care nurse helps if she is can get to help me. tested positive for C knew that I had lost went to work anywa suddenly shuts off. (green) that day. Will myself. On the questost your taste or smeal training the curtain training to the curtain training tr	5 p.m., An open side meal side of the B hall COVID unit ays.  10 p.m., V20 (CNA) stated, "I VID positive only hallway. The ck here with me also works d A hall. I have two assister for. If I need assistance the back here or whoever else I This past Monday (11/23/20) I COVID. Before I got to work, I my taste and smell, but I y. It's just like they say it just I was working on C Hall hen I got to work, I screened stionnaire it asks if you have nell, and I answered no. I hille before I told anyone I was				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND FOR	OF CONTROL OFFICE	IDENTIFICATION NOMBER	A. BUILDING:		COMPLETED		
	,	IL6009427	B. WING		12/10/2020		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
TOULON	I REHAB & HEALTH O	CARE CENTER HIGHWAY TOULON,					
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROVIDENCY)	.D BE	(X5) COMPLETE DATE	
S9999	Continued From pa	nge 12	S9999				
	having symptoms. \	When I told them, I was for COVID, and of course it a. They did not send me					
D.	11/19/20 to 11/25/20 answered no to hav symptoms. The que 11/24/20 that V20 a or worsened cough (vomiting or diarrhe	creening Questionnaire, dated 10, documents that V20 ving any COVID related estionnaire also documents on answered yes to having a new and gastrointestinal upset ea), and on 11/25/20 V20 aving a sore throat and new ell.					
	document that V20	RNA (COVID 19) test results was COVID positive from a collected 11/23/20 and 20.					
Œ	that V20 was rapid	ng and Results documents tested on 11/23/20 for 19 symptoms, and V20 was	÷	121			
	11/23/20 to 11/25/20 the following shifts/i	Assignment sheets, dated 0, document that V20 worked halls: 11/23/20 1st shift (6:00 on C and D hall; 11/24/20 and n B hall.			8		
	Nurse) was working is 100% positive. W	D p.m., V17 (RN-Registered g E hall. V17 stated, "Our hall Ve go back through the it, leave, take breaks, or if we	70				
	tested positive for C	D p.m., V22 (CNA) stated, "I COVID on 11/21/20. On ving symptoms. I had a					

Illinois Department of Public Health STATE FORM

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(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6009427	B. WING		12/10/2020	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
TOULON	REHAB & HEALTH C	CARE CENTER HIGHWAY TOULON,				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE
\$9999	Continued From pa	ge 13	S9999			
	work. When I scree symptoms, and V1 rapid test on 11/18/2 and they did the ontesting, I continued on 11/18/20, and wishift on the 11/21/20 positive and I finish	st didn't feel right when I got to med myself I said I had rapid tested me. She did a 20 and it came back negative, e you send off. After the on with my shift on the E hall orked after that. During my 0, I was notified of being ed my shift. On 11/22/20, I y bad and I haven't worked	01: 			
10.30	V22's Employee Sc 11/12/20 to 11/18/20	reening Questionnaire, dated 0 and 11/19/20 to 11/21/20, answered no to having any ptoms.				5
	document that V22	RNA (COVID 19) test results was COVID positive from a collected 11/18/20 and 0.	A			
	11/18/20 to 11/21/20 the following shifts/	Assignment sheets, dated 0, document that V22 worked halls: 11/18/20, 11/19/20, and 6:00 a.m. to 2:00 p.m.) on E	7			
	worked last on 11/2 outbreak started. I value I didn't answer you to work. By the was obnoxious and started. I contacted evening when I got symptomatic. I reall swabbed Monday a test that takes up to	o p.m., V24 (CNA) stated, I 1/20 on the E hall where the went to work with a headache, yes on the screening when I end of my shift, my headache I had a cough that had V1 (Administrator) that home and told her I was y felt sick Monday. I was t the facility, but that was the o 72 hours for results. We got sday, and that one came back				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6009427	B. WING		12/10/2020	
NAMEOF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	35	
TOULON	REHAB & HEALTH C	CARE CENTER HIGHWAY TOULON,				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE COMPLE	ETE
S9999	Continued From pa	ge 14	\$9999			
	positive staff worke residents. V25 (LP) the red zone of E handle assistance, back to help him with positive at the time. positive."  V24's SARS CoV R dated 11/23/20 and	rk after the 11/21/20 . COVID d back with COVID positive N) was working as a CNA in all with me one evening. If V25 I was the one assigned to go th residents. V25 was COVID It was after that when I tested RNA (COVID-19) test results, reported on 11/26/20, was positive for COVID-19.				
7.4	The facility's Daily A 11/23/20, documen (2:00 p.m. to 10:00 On 12/2/20 at 10:30 Alzheimer's coordin Friday, but I also pidloor nurse. Normal working on the Alzhpick up hours in the shift and 2nd shift moth A and B hall at p.m. through 3rd sh A and B, but also copositive on 11/18/20 the test that was se symptoms started brunny nose and che tested that day for the back negative. So I was still having symbefore I got to work and have a rapid te back negative, and tested next on 11/10	Assignment sheet, dated ts that V24 worked 2nd shift	<b>38</b>			
Illinois Denar		g lot during the rapid routine				

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING IL6009427 12/10/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **HIGHWAY 17 EAST** TOULON REHAB & HEALTH CARE CENTER **TOULON, IL 61483** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) Continued From page 15 \$9999 S9999 tests. I was still having symptoms, but it was negative. I continued to work. The last time I was tested was 11/18/20. This was our routine testing day. They were actually doing the test that they send off and a rapid test at the same time. I was still symptomatic, and my test results finally came back positive, both the rapid and the one that was sent off. I was off work after that. The local health department told me I was assumed positive from 11/11/20 since that was when my symptoms started." V21's Antigen Testing and Results, documents that on 11/11/20, V21 was routine COVID-19 tested with negative results received on the same day (Rapid test), and on 11/12/20 was Rapid tested because of having COVID symptoms with those negative results being received the same day, it also documents that V21 was Rapid routine tested again on 11/16/20 with that result being negative, and Rapid routine tested and having COVID symptoms again on 11/18/20 with these results being positive for COVID-19. V21's SARS CoV RNA (COVID-19) test results, dated 11/18/20 and reported on 11/21/20, document that V21 was positive for COVID-19. V21's Employee COVID Screening Questionnaire, dated 11/9-11/12/20, documents that V21 self answered that she was not exhibiting any symptoms of COVID-19. V21's Employee COVID Screening Questionnaire, dated 11/12-11/17/20, documents on 11/12/20 at 4:00 p.m., that V21 left the following symptoms blank without an answer: Headache, new loss of taste or smell, any new

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onset of shortness of breath, any new or

worsening fatigue, runny nose or nasal drainage,

**FORM APPROVED** Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ B. WING 1L6009427 12/10/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **HIGHWAY 17 EAST TOULON REHAB & HEALTH CARE CENTER TOULON. IL 61483** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE. PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 16 S9999 S9999 gastrointestinal upset (vomiting or diarrhea). The Questionnaire also documents on 11/13/20 at 8:00 a.m. and 12:00 p.m., 11/16/20 at 8:00 a.m., 12:00 p.m., and 4:00 p.m., and 11/17/20 at 9:00 a.m. and 1:00 p.m., that V21 answered yes to exhibiting the symptoms of muscle pain and runny nose/nasal drainage. V21's Hours Worked Simplified Report, dated 12/10/20, documents that V21 worked 11/11/20 from 8:30 a.m. to 4:45 p.m., 11/12/20 from 8:00 a.m. to 5:00 p.m., 11/13/20 from 8:15 a.m. to 5:15 p.m., 11/16/20 from 8:15 a.m. to 5:00 p.m., and 11/17/20 from 9:00 a.m. to 5:30 p.m. on the E hall as the Alzheimer's coordinator. The facility's COVID Room list, dated 11/28/20, documents that the each resident in the facility who has tested positive for COVID-19 along with their location when they were diagnosed. The first COVID-19 resident (R9) was on 11/13/20 and she was located on the E hall. The E hall then had the following positives isolated to that hall only: 11/15/20 R10 and R3, 11/20/20 R11, R12, R13, R14. R15, and R16. On 11/21/20, four more residents (R4, R17, R18, R19) on the E hall tested positive, as well as two residents (R29, R30) on the C hall and R35 on D hall. On 11/22/20, R20 and R21 tested positive on the E hall and R24 on the B hall. On 11/23/20, R22 and R23 tested positive on the E hall, to bring the E hall to 100% COVID positive. Also, on 11/23/20, R31 tested positive on the C hall. On 11/24/20, R25 who was located on the B hall tested positive. On 11/25/20, R1, R34, and R35 from A hall, R26 and R27 from B hall, and R32 from C Hall tested positive. On 11/26/20, R28 from B hall

Illinois Department of Public Health

COVID-19.

tested positive. On 11/28/20, R36 from A hall, R2 and R33 from C hall, and R36 tested positive for

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		IL6009427	B. WING		12/10/2020	
NAMEOF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TOULON	REHAB & HEALTH C	CARE CENTER HIGHWAY TOULON,				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETE	
S9999	Continued From pa	ge 17	S9999			
	On 11/30/20 at 12:0 shift and 2nd shift, of the A and B hall. On assigned to A and B assigned to C, D, ar "The PPE requirement portion of B hall is to gown and new set of the residents' room, gown and gloves an should have known side of B hall is trea precautions, meaning with each entrance before leaving the rewashing/sanitizing he "Every two hours, he responsible for clear The staff have been need disinfected, and the disinfectants are meal loaded dietary leaves them. The remeals to the resider cart that goes into the red zone of Ecurtain area. They securtain and reach the distribute them. Diet zone and collect the carts should be disir	on p.m., V1 stated, "On 1st one nurse is assigned to both a 3rd shift, one nurse is hall, and the 2nd nurse is hall, and the 2nd nurse is hall, and the yellow zone of enter each room with a new of gloves. Then, when exiting a staff should remove their had perform hand hygiene. V13 that each resident on yellow ted as being on isolation and a new set of PPE is applied to a room, and removed from as well as her hands." V1 also stated, busekeeping staff is ultimately ning high contact surfaces and what the contact times for each distributes the carts to the red zones and ad zone staff distributes the fits. E hall uses an enclosed the unit. The open sided cart is hall does not go into the hould leave the cart at the rough to get the meals, and sary staff go back to the red dietary carts. The dietary	\2			
æ	was started on the E positive resident. Th	p.m., V3 (Infection I, "On 11/13/20, a red zone hall with our first COVID-19 e hall was separated by a kept moving forward as more				

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		1L6009427	B. WING		12/	12/10/2020	
	PROVIDER OR SUPPLIER	ARE CENTER HIGHWAY	DRESS, CITY 17 EAST IL 61483	, STATE, ZIP CODE			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION SHOULD BE COMPLETE THE APPROPRIATE DATE		
S 9999	was 100% positive of Hall was converted development of positive of E Hall. The COVI staff to work only the during their shift. All worked by the same hall is worked by the working the C-hall." staff self-screen the check them when I and then 3rd shift is after they've left. If a symptoms, they showork. If they answer have a high temperature wi is exhibiting COVID-sent home or have r If the rapid test combem home. However symptoms we may knowled possibly work contacted us prior to	pared on that hallway, until it on 11/23/20. On 11/21/20, But to a red zone with the itive COVID-19 cases outside D units do not have dedicated a COVID units red zone three shifts, A and B hall are an unse. On 3rd shift, the E a A/B hall nurse or the nurse V3 also stated, "All of the mselves at the D hall and! get to work. I check 2nd shift checked when I get to work a staff member has all be calling me before they yes on the questionnaire or ature when they screen them contacting me. Anyone with a ll be sent home. If someone 19 symptoms they will be apid COVID test completed, es back positive, we send	\$9999				
	tested and/or advise have notified us righ  The facility's up to da Testing list for Resid 12/10/20, documents case of COVID-19 o tested positive for Co 56 have expired as a	d to stay home. She should t away."  ate West Region COVID ents, provided by V1 on s that since the facility's first in 11/10/20, 56 residents have OVID-19, and eight of those is result of COVID-19.		9			
*:	The facility's room ro provided by V1, docu reside in the facility.	ster, dated 11/30/20 and uments that 76 residents					

PRINTED: 01/26/2021 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING IL6009427 12/10/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **HIGHWAY 17 EAST TOULON REHAB & HEALTH CARE CENTER TOULON, IL 61483** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) S9999 Continued From page 19 S9999 "A"