STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008312	A. BUILDING: _____ B. WING _____	C 06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE WILMINGTON	555 WEST KAHLER WILMINGTON, IL 60481

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S 000	Initial Comments Complaint Investigation 2274856/IL148214	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.696b) 300.696d)6)13) 300.696f)4) 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 Guideline for Isolation Precautions, Hospital Respiratory Protection Program Toolkit, and the Occupational Safety and Health Administration ' s Respiratory Protection Guidance. Section 300.696 Infection Prevention and Control 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 13)Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Section 300.696 Infection Prevention and Control f)Infectious Disease Surveillance Testing and Outbreak Response 4) Upon confirmation that a resident, staff member, volunteer, student, or student intern tests positive with an infectious disease, or displays symptoms consistent with an infectious disease, each facility shall take immediate steps to prevent the transmission by implementing practices that include but are not limited to cohorting, isolation and quarantine, environmental cleaning and disinfecting, hand hygiene, and use of appropriate personal protective equipment. These regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to implement infection control policies and procedures for the isolation of roommates of Covid-19 positive residents to prevent the spread of infection. This failure has the potential to affect 37 residents (R1-R3, R5, R9-R41) in the secured behavior unit who were not Covid positive. The Census Sheet provided on 6/23/22 showed that R1-R5, and R9-R41 all reside in the secured behavior unit. The findings include: R7's 6/19/22 Progress Notes from 1:47 PM showed a positive rapid Covid-19 result with R7 exhibiting Covid-19 symptoms. On 6/23/2022 at 11:05 AM, V3 (Infection Preventionist) stated the facility is in outbreak status, and that the first resident who tested positive was R7 on 6/19/22 (four days earlier). V3 stated R7 was left in his original room in the	S9999		

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S9999	Continued From page 2 secured dementia unit, and R7's roommates (R4 and R6) were moved from the secured dementia unit and placed into separate rooms in the secured behavioral unit. V3 continued, stating more residents tested positive on 6/20/2022, 6/21/2022 and 6/22/2022, and that more room moves were made. At the time of the survey, the facility had 33 confirmed resident and staff cases of Covid-19. V3 also explained that the facility's isolation policies include using "red zone" isolation for residents who are positive for Covid-19, and "yellow zone" isolation for residents who have been exposed to a person who tested positive for Covid-19. V3 stated "yellow zone" residents would not have symptoms of Covid-19, and they still test negative. V3 stated the facility does not cohort residents who have been exposed to Covid-19 ("yellow zone" residents) with residents who have not been exposed to Covid-19. On 6/27/22 at 10:20 AM, V3 stated that R6 became symptomatic and tested positive for Covid-19 on 6/22/2022 (three days after his exposure to R7, and after living with R3 and R5 for those three days). V3 stated R6 moved back into the red zone with R7, his former roommate. On 6/23/2022 at 2:30 PM, the secured behavior unit had a total of two rooms marked with signs indicating "yellow zone" isolation. The two rooms housed R1-R5. None of the other 11 rooms in the secured behavioral unit were designated as "yellow" or "red" zones of isolation. On 6/27/22 at 11:20 AM, R5 (the former	S9999		

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S9999	Continued From page 3 roommate of the now Covid-positive R6) wandered the secured behavioral unit hall with his mask below his nose. At 11:50 AM, R5 was in the hall again with his mask below his nose, carrying his trash down the hallway. On 6/27/2022 at 10:20 AM, V3 stated when R7 tested positive on 6/19/2022, R7's two roommates (R4 and R6) were each moved into two other separate shared bedrooms. V3 stated that R4 was moved into a room with R1 and R2, and R6 moved into a room with R3 and R5; however, V3 also stated that R1, R2, R3 and R5 had no prior known exposure to Covid-19. V3 confirmed R4 and R6 should not have been placed in rooms with R1, R2, R3 and R5. On 6/27/2022 at 1:24 PM, V1 (Administrator) stated the facility notified her via phone of R7's positive Covid-19 result on 6/19/2022 around 3 PM. V1 stated the room moves occurred between 3-7 PM. V1 stated three facility staff who were on call were involved in the room moves on 6/19/2022. V1 stated " ...Bottom line is- a poor decision was made." On 6/28/2022 at 4:32 PM V7 (Medical Director) stated he expects the facility to comply with facility policies and the Center for Disease Control (CDC) guidelines for Covid-19, including placement of residents who had close contact with residents who tested positive for Covid-19. V7 confirmed that residents not exposed to Covid-19 are placed at increased risk of contracting it when they are incorrectly housed together in rooms with residents who have been exposed to Covid-19. The facility policy, Infection Control- Interim policy addressing healthcare crisis related to Human	S9999		

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S9999	Continued From page 4 Corona Virus dated 8/13/2021 documents roommates of residents with Covid-19 should be considered exposed and potentially infected and placed under transmission-based precautions (yellow zone isolation). If possible, roommates should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for a total of 14 days after their last exposure. The potentially exposed roommate should remain in a single room under transmission-based precautions and continue to be monitored closely for the development of symptoms. The facility's Resident Vaccine Matrix showed R4 received his second Covid-19 vaccination on 9/21/2021 and did not receive any boosters. The Resident Vaccine matrix showed R5 received his second Covid-19 vaccination on 7/21/2021 and did not receive any boosters. The Center for Disease Control's Interim Infection Prevention and Control Recommendations to Prevent Covid-19 Spread in Nursing Homes, last updated 3/29/2021, shows residents who had close contact with someone infected with Covid-19 and are not up to date with all recommended COVID-19 vaccine doses and who have had close contact with someone with Covid-19 infection should be placed in quarantine after their exposure, even if viral testing is negative. (A)	S9999		