Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED IL6001226 B. WING 06/15/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2508 ST. JAMES ROAD **BROTHER JAMES COURT** SPRINGFIELD, IL 62707 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Z 000 COMMENTS Z 000 **COVID-19 SURVEY** Z9999 **FINDINGS** Z9999 Statement of Licensure Violations: 350.620a) 350.760a) 350.769a) 350.769h)1)2)3) 350.1210b) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents, and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.760 Infection Control Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 III. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 III. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed. Attachment A Section 350.769 - COVID-19 Vaccination of Statement of Licensure Violations Facility Staff

Illinois Department of Public Health

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

TITLE

(X6) DATE

<u>Illinois</u>	Department of Public	Health			_ >> =	FORM	APPROVED	
STATEM	ENT OF DEFICIENCIES AN OF CORRECTION	ICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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Z9 999	Continued From pa	ge 1	Z9999	50				
	who are up to date not up to date on C unvaccinated with a subsection (b)(3), a subsection (c). Faci	I maintain a record of staff on COVID-19 vaccinations, OVID-19 vaccinations, and on exemption pursuant to not test results required per lities that are not required to				5 8 ⁷⁸		
	lesting data into the Network (NHSN) sh Department weekly available at https://app.smartshe	gregate vaccination and National Healthcare Safety all report this data to the utilizing the online form set.com/b/form/fa2d7abfb102	20.				Ş	
	h) The facility shall reach staff persona's accordance with fed regarding COVID-19 including the followir 1) Proof of vaccinations are supplied to the followir states are supplied to the followir supplied to the facility shall reach shall reach supplied to the facility shall reach supplied to the facility shall reach	0744. naintain documentation in confidential medical file, in eral and state privacy laws, vaccinations and tests, ng:	7.00	14 10 10 1				
10	person; and	VID-19 tests for each staff from the vaccination.	= 0 (3)			ā	111	
881	Section 350.1210 He	ealth Services	!				204.223	
si n	b) The facility si necessary to maintai physical health.	nall provide all services n each resident in good		c • \$11	= 11 11			
	These Regulations w by:	ere not met as evidenced		955 8•	, ⁷	8		
	failed to: 1. Develop and imple	all staff are fully vaccinated	-					

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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 JL6001226 B. WING 06/15/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2508 ST. JAMES ROAD **BROTHER JAMES COURT** SPRINGFIELD, IL 62707 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Z9999 Continued From page 2 Z9999 employee Covid-19 vaccination status including specific vaccinations received and/or documentation of religious or medical exemption status. These failures have the potential to affect all 68 individuals (R1-R68) residing in the facility. Findings include: An undated roster of residents provided at the beginning of the survey documents 68 individuals reside in the facility, 11 individuals function at the level of Mild Intellectual Disability (R1, R6, R10, R11, R16, R35, R50, R57, R58, R65 and R66)19 individuals function at the level of Moderate Intellectual Disability (R2, R3, R8, R12, R17, R18, R22-R24, R26, R27, R28, R33, R42, R45, R52, R55, R62 and R64), 17 individuals function at the level of Severe Intellectual Disability (R14, R15, R21, R29-R32, R34, R36, R37, R40, R41, R49. R53, R56, R59 and R60) and 21 individuals function at the level of Profound Intellectual Disability (R4, R5, R7, R8, R13, R19, R20, R25, R38, R39, R43, R44, R46-R48, R51, R54, R61, R63, R67 and R68). Undated Employee Roster documents 62 employees are employed by the facility. E1/Administrator, E2/ Director of Nursing, E3/ Director of Housekeeping, E4-E25/DSP, E26/Activity Director, E27/Resident Care Manager. E28/Resident Care Supervisor, E29-E32/Registered Nurses, E33-E35/Licensed Practical Nurses, E36-E45/Dietary, E46/Dietary Director, E47-E50/Housekeeping, E51-E52/Laundry, E53-E54/Maintenance, E55/Medical Records, E56-E57/Social Services, E58/Social Service Staff Trainer, E59/Social

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(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE ID (X5) COMPLETE DATE **PREFIX** TAG TAG **DEFICIENCY**)