STATEME	Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008023 NAME OF PROVIDER OR SUPPLIER STREET AD		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
NAMEORI					12/	29/2022
INAME OF	PROVIDER OR SUPPLIE	OTTOETAD		STATE, ZIP CODE		
RIVERSI	DE FOUNDATION		EST HIGHWA			
ļ			SHIRE, IL 6	30069		
(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 APPR DEFICIENCY)	UI D RE	(X5) COMPLETE DATE
Z9999	Continued From p	page 1	Z9999	21		
- 1. II	8)Interim Infection	I in Healthcare Personnel Prevention and Control s to Prevent SARS-CoV-2		S4	8 S	
	a garan an	nts are not met as evidenced by:	200	E* #5		1
	interview, the facil Centers for Diseasisolation and quar. R5, R6 and R10) i positive for the Co. The five clients we roommates, who tagging infection. This has the potential clients (R2, R4, R2) who resided in the shared with the clients (R8) who reside in R88) who reside in R88.	ere not separated from their ested negative, for the Covid atial to affect the remaining 7, R8, R9, R11, R12 and R13), affected bedrooms they ents who tested positive, for the and there other clients (R14 -				
	entrance into the fathis surveyor asked Covid 19 in the building in the building asked E1 if they are prevent the spread building. E1 stated R1 and R3 have C roommates. R1's roommate is R4. E	w with E1 (Administrator) upon acility on 12/19/22 at 10:07am, of E1 if they have any active ilding. E1 offered they have 3 uilding that have an active at this time. This surveyor e in a room by themselves, to of Covid 19 throughout the they are not. E1 stated both ovid, but they both have commate is R2, and R3's 1 stated R5 is in a room asked why they did not move	N			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008023		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			СОМ	(X3) DATE SURVEY COMPLETED R 12/29/2022		
NAMEOF	PROVIDER OR SUPPLIEF	STREET AD	DRESS, CITY.	STATE, ZIP CODE	500		144	LSIZUZZ	
RIVERS	IDE FOUNDATION	14588 WE	ST HIGHWA SHIRE, IL 6	Y 22					
(X4)ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			I D RE	(X5) COMPLETE DATE	
Z9999	Continued From p	age 2	Z9999					 	
V E	R2 and R4 out of to clients. E1 stated to already been export to move them out E1 was asked what stated they routine	the room with the Covid positive they just figured they have used, so it did not make sense of their rooms. It day they tested positive. E1 test all the individuals every	. 1					22	
	results on 12/15/22 was asked if the of and R4, were allow	on 12/14/22, and received the 2 at 4:45pm, approximately. E1 ther negative individuals, R2 wed to leave the room in which		€	3 8			ž	
	other clients who li R1, R3 and R5 eat will be letting R1, F because their 5 da	I. E1 stated they both leave and and eat meals with all of the ve in the building. E1 stated in their rooms. E1 stated she R3 and R5 out of isolation, ys of required isolation will be		o₹ €				2 /	
!	doors of the Covid isolation carts cont Personal Protective	ey have signs posted on the 19 positive clients, with aining the appropriate Equipment(PPE), so staff will	#3 *** ***			% %		46	
	thinks they have a bedrooms, so staff	they enter the affected ed they do not. £1 stated she dedicated garbage can in the can remove their gowns and exit the affected bedrooms is reside in.	×	53 55					
	date at 10:55am. Noutside of any of the	ed the facility on this same lo isolation carts were set up ese bedrooms with COVID and all bedrooms door lacked	(4)				30° E4		
94 C	the appropriate isol During an interview and time, E1 was a	ation signage. with E1 on this same date sked where staff can get the stated they can find all the	8 W D	4					
	PPE in the time clo type of PPE is requ	ck room. E1 was asked what ired when staff enter a Covid 1 stated they wear a maskand		3				£6 (1)	

43	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/		A. BUILDING	(X3) DATE SURVEY COMPLETED R 12/29/2022		
IL6008023		B. WING				
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY,	STATE, ZIP CODE	- "	
	DE FOUNDATION		EST HIGHWA			
(IAEKOID	EFOUNDATION	LINCOLN	SHIRE, IL 6	80069		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPLIANCE OF	ULD BE	(X5) COMPLE DATE
Z9999	Continued From pa	ne 3	Z9999	DEFICIENCY)	100 A	
2000	_ W1000000000000000000000000000000000000	N 2	+ C.	4 5		
	While walking throu	igh the facility, E8 (Nurse) was			2.2	
	noted to be wearing	his mask down under his	16. 1	□ H		
	chin. E8 did not hav	e his mouth or nose covered,		1.6		1
5/2/	even though the fac	cility is in an active Covid 19		100		
	outbreak.		A	23		
7.				N .		
H 1	At a second interview	ew on 12/20/22 at 9:50am, E1				2000
3	stated she forgot to	tell this surveyor they had two				
	other individuals wh	o also tested positive for	,			
		2. E1 stated those two				Ì
[]	individuals are R6 a	and R10. E1 offered they also		=-		
	had roommates, an	d did not move those clients				
1.5	out of their bedroon	n either. E1 offered those		:: '`		1.
	individuals are R7,F	R8, R9, R11,R12 and R13. E1				
	offered she just for	got to tell this surveyor about		92 of 6		1
76)	these other individu	als, because they are now out				
	of isolation.			45		ĺ
	El added, "we had	them in isolation for ten		***		
	days."	let D4 D0 1 D5 1 C				- 4
	isolation this marri-	let R1, R3 and R5 out of				
	solation this morning	ng (12/20/2022). E1 was	1	W 11		
25 89	asked why Ro and I	R10 required 10 days of		00	7	
	ofication E4 state	3 and R5 only required 5 days		6477 618		
3 2	onsoration. Enstate	ed she is not sure, but just			19200	ĺ
= a	tilougiit air tilat was	needed was the 5 days.		*	200	
e .	and if they are follow	their Covid 19 policy states,	77		= "	
	guidelines.	wing the most current CDC	* Ta			
		d 19 policy is not that specific.		156		- 51
	E1 stated their Covi	od 5 dovo of inclotion is all				.8.
91	that is pooded. Et a	ed 5 days of isolation is all	İ			
	R1 R3 and P5 will	stated after the five days, then need to wear a mask		+ _ 150 m _		-
100	whenever they are	out of their bedrooms. E1 was		# M		
	asked if those 3 clie	ents will be compliant with	,0	Z		
1,	wearing a mack for	the next five days. E1		W		36
	responded she think	re so				10
		by this surveyor the most		1		* 1
	current isolation avial	delines from the CDC states		20.4		
5 4	for congregate setti	ngs, clients who test				
	positivefor Covid 10	need to be in isolation for a		967 (10)		

PRINTED: 02/28/2023 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 IL6008023 B. WING 12/29/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE RIVERSIDE FOUNDATION 14588 WEST HIGHWAY 22 LINCOLNSHIRE, IL 60069 SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 4 Z9999 Z9999 total of ten days. E1 stated she was not aware of that requirement. E1 was asked if the bedrooms affected with R6 and R10, had isolation carts or signage on the doors. E1 confirmed they did not put any signs up on either door, and did not have isolation carts outside of their bedrooms. E1 was asked how staff will know that those specific rooms contained Covid 19 active infections. E1 stated they did send out an email to staff. E1 was asked how visitors would know. E1 stated she hoped staff would be able to tell them, prior to entering a potential Covid positive bedroom. E1 was asked if she could provide this surveyor with the facility's current policy for the Covid 19 infection. The policy was received on 12/19/22. The policy is entitled, "Covid -19 Policies and Protocol for Testing and Quarantine Plan. The policy states that they are in accordance with emergency updated regulation issued by the Centers for Medicare and Medicaid Services(CMS), and Lake County Health Department. Under, response to a positive case, the protocol directive indicates that if a client tests positive for Covid 19, they will be guarantined to their room for a total of five days. If they test positive after five days, they will not be considered a new case, and will remain out of quarantine. The policy does not direct staff to remove the a roommate out of the affected clients bedroom. should the roommate have a negative Covid 19

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The policy does not state appropriate signage should be placed on the door, and does not indicate what type of PPE the staff should wear, should they need to provide care to the

STATE FORM

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Illinois Department of Public STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		IL6008023	B. WING			R 29/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	1 12.14	LSIZUZZ		
RIVERSI	DE FOUNDATION	14588 WE	ST HIGHWA	AY 22			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	SHIRE, IL 6				
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	BE COMPLETE	
Z9 999	Continued From pa	age 5	Z9999	1/4	45 W	1 27	
).* W=	quarantined clients 19 infection.	who do test positive for Covid		= " '	18		
450	Nursing Homes an Care facilities, with	ated Interim Guidance for d Other Licensed Long-Term a revision date of November	7.01	# # # # # # # # # # # # # # # # # # #	9	3.	
Œ	provides guidelines Covid-19 in nursing	s that this interim guidance s to mitigate the spread of phomes, and other long term	۵.		N II		
#2 25 E	services, including the Developmental The source control providers are an ar a well fitted mask. Health care person suspected or confil	provide skilled personal care Intermediate Care Facilities for Intermediate Care Facilities for Iy Disabled (ICF/ID). options for health care oproved N95 filter or higher, or Under Universal PPE for It states that if a client is med to have Covid-19, the Ir must wear an N95 respirator,	13		ŧ	3 5 '0	
** 28.1	eye protection, gov The document con dedicated medical when caring for a r confirmed Covid -1 Under client placer	n and gloves. tinues, indicating that equipment should be used esident with suspected or 9 infection. nent for a client with confirmed				34 2 ₄ A	
# #	infected client in a Transmission-Base door should be kep Ideally, the client sl bathroom. Limit the	t directs facilities to place the single person room, using a Precautions (Isolate). The st closed (if safe to do so). Hould have a dedicated a transport and movement of	3		. S.		
2 K 18 17 I	the client outside of essential purposes other positive Covid Transmission-Base confirmed Covid-19 stay in isolation for	f the room to medically Cohorting may occur with d-19 clients. Under duration of d Precautions for clients with the report directs facilities to a minimum on 10 days since eared or first diagnostic test.	9' II 40		0 4		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING: _ R B. WING IL6008023 12/29/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **14588 WEST HIGHWAY 22** RIVERSIDE FOUNDATION LINCOLNSHIRE, IL 60069 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETE DATE PREFIX TAG TAG DEFICIENCY)

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