Illinois Department of Public Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED				
			A. DOLDING.	<del>.</del>	- 18				
1L6002182		B. WING		05/18/2023					
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
VINES AT COUNTRYSIDE 971 BODE ROAD ELGIN, IL 60120									
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE				
S 000	Initial Comments	200	S 000						
	Annual Licensure S	Survey		2 ×					
\$9999	9999 Final Observations		S9999						
	Statement of Licensure Violations		70						
	330.1135a 330.2000 Section 330.1135 Tuberculin Skin Test Procedures			= 2					
50	Tuberculin skin tests for employees and residents shall be conducted in accordance with the Control of Tuberculosis Code (77 III. Adm. Code 696).		5 A	441 27	13				
	a)TB Risk Assessment. Every health care setting shall conduct initial and ongoing evaluation of the risk for transmission of M. tuberculosis, regardless of whether patients with suspected or confirmed active TB disease are expected to be encountered in the setting. The TB risk assessment shall address administrative, environmental, and respiratory-protection controls needed for the health care setting and shall be reviewed at least annually.		Ψ.						
=	This regulation was	NOT MET as evidenced by:		#: #:					
	failed to perform an risk assessment for	and record review, the facility ongoing tuberculosis (TB) residents. This failure can ats currently residing in the							
	Findings include:			Attachment A					
	On 05/17/2023 at 1	1:50AM, V2 (Registered		Statement of Licensure Violation	ns				

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(X2) MULTIPLE CONSTRUCTION

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

TITLE

(X6) DATE

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY

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

STATEMENT OF DEFICIENCIES

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUILDING:			COMPLETED	
		IL6002182	B. WING		05/18/2023	
			- · · · · · ·			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
S9999	tests upon admission facility and the 2-steethere, they accept in medical record. She	ge 1 esidents do TB quantiferon on or if they come from a ep Mantoux test was done t and put it in the resident's e also said there are no annual ts done on residents	S9999		* .	
	On 05/17/2023 at 2 stated that no TB ri on residents after a Medical records rev	:25PM, V6 (Nursing Director) sk assessment is being done dmission TB test is done. viewed and did not indicate sessments on residents.				
	Every facility shall of rules entitled "Food Adm. Code 700).	Food Handling Sanitation comply with the Department's Service Sanitation" (77 III.				
	review, the facility f food scoop was no container for sanita effects three (R4, F reviewed for food h also failed to ensur stored on the floor, after entering the k drinks in the kitche	ion, interview and record ailed to ensure that the dry t stored inside the food try reasons. This failure R5, R6) of three residents andling sanitation. The facility e that cooking oil was not and staff washed their hands itchen and handling food and n. This failure has the all residents receiving food or				

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING: B. WING IL6002182 05/18/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 971 BODE ROAD **VINES AT COUNTRYSIDE ELGIN. IL 60120** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX. DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 S9999 Continued From page 2 On 5/16/2023 at 10:10 AM with V3 (Cook) during initial kitchen tour, observed kitchen for dry storage and refrigerators. Observed bulk food thickener has a silver measuring cup sitting inside the thickener container. Surveyor asks about the cup in the thickener. V3 removes the cup and states "I do not keep the cup in there for sanitation reasons" and to avoid contamination with germs. In dry storage room there are 2 large boxes of oil sitting on the floor. One unopened and another is opened. The opened box of oil, shows the plastic oil container with white bottle cap that's sitting inside it. The box is oil stained near and below the opening. V3 states three residents receive pureed diets. On 5/17/2023 11:17 AM dry storage room door open and able to observe the same two containers of cooking oil on the floor. On 5/17/2023 11:18 AM observed V3 puree pork chops with water and thick-it. V3 states it is the same thick it that is bulk stored in the other room that we saw yesterday. V3 states three residents receive pureed diets. V3 states that it is okay to store cooking oil on the floor because they are in a box and plastic. On 5/17/2023 at 1:58 PM V1 (Administrator) states R3, R4, and R5 receive pureed diets. 5/17/2023 at 11:30 AM V4 (Dietary Aide) cleaned her hands and walks over by the food and put on blue gloves. At 11:31 AM V4 grabbed the door handle with blue gloves still on and left out of the kitchen. V4 comes back into the kitchen about a minute later with blue gloves still on while pulling a food tray. V4 did not wash her hands after

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entering the kitchen. V3 then starts plating the food and hands them to V4. V4 grabs each tray

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AND PLAN OF CORRECTION   (X1) PROVIDER/SUPPLIER/CLIA   IDENTIFICATION NUMBER:		A. BUILDING:			COMPLETED	
	et.	IL6002182	B. WING	<u> </u>	05/1	18/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADO	DRESS, CITY, S	STATE, ZIP CODE		
VINES A	T COUNTRYSIDE	971 BODE ELGIN, IL				2
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	and then places the (Dietary Aide) come with another rolling that V4 handed her On 5/17/2023 at 11 the kitchen through not wash her hands coffee cups that are island and just insid them to the counter kitchen. V5 then stated on 5/17/2023 at 11 the staff in the kitch and V5 is making to The facility's Kitched documents the follow or dietary aides entwashed. Hands must be ginning the follow handling clean dish clean, single-use gomust be washed af actions: touching a contaminate hands.  The facility's Food.	oth hands, puts top on them em on the food cart. V7 es just inside the kitchen door tray 3 times to collect the food.  :35 AM V5 (CNA) comes into the double doors and does and starts grabbing colored e at the end of the kitchen de the double doors. V5 takes over on her right side in the earts pouring hot drinks.  :40 AM surveyor asks V3 who hen are. V3 states that is V5 ea.  In Hand Hygiene Policy owing: When food prep staff fer the kitchen, hands must be ust be washed before wing tasks: Preparing food, hes or utensils, putting on loves, changing tasks. Hands ther performing the following any surface that might is.  Safety Policy documents open refrigerated at 40 degree	\$9999			
3				£		

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