STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004188	A. BUILDING: _____ B. WING _____	C 09/21/2020

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TWIN LAKES REHAB & HEALTH CARE	310 EADS AVENUE PARIS, IL 61944

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S 000	Initial Comments A Focused Infection Control Survey/COVID-19 Focused Survey was conducted by the Illinois Department of Public Health on September 21, 2020. Survey Census - 38 residents Total Sample - 28 residents Complaint Investigation 2067115/IL126618	S 000		
S9999	Final Observations Statement of Licensure Violations 300.696a) 300.696b) 300.696c)7) 300.1210b) 300.3240a) Section 300.696 Infection Control a) 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 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed. b) A group, i.e., an infection control committee, quality assurance committee, or other facility	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 entity, shall periodically review the results of investigations and activities to control infections. c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340): 7) Guidelines for Infection Control in Health Care Personnel Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on interview and record review the facility failed to follow facility policy and local health department guidance to promptly develop a COVID-19 Unit and move infected residents away from non-infected residents for twelve of twelve	S9999		

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residents (R6, R16, R17, R19, R20, R21, R22, R23, R24, R25, R26, R27) reviewed for infection control in the sample of 29 residents. This failure resulted in R6, R23, R24, R25, R26 and R27 being unnecessarily exposed to an infectious disease for an extended period of time.

The facility failed to ensure R16, R17, R19, R20, R21, and R22, who tested positive for SARS-CoV-2 or the SARS-CoV-2 Antigen, were promptly moved to a COVID-19 Unit and away from their roommates, R6, R23, R24, R25, R26 and R27, who were not positive for SARS-CoV-2 or the SARS-CoV-2 Antigen. R6, R23, R25, R26 and R27 later tested positive for SARS-CoV-2 or the SARS-CoV-2 Antigen.

Findings include:

The COVID-19 Cohorting of Residents policy dated 8/26/20 states:

"Purpose: To minimize interactions of infectious individuals from non-infected individuals."

"Identify space within the facility to be dedicated to monitor and care for residents with COVID-19. Ideally this space should be physically separated from other rooms that house residents without confirmed COVID-19. (Separate floor, wing or cluster of rooms) Identify HCP (Health Care Providers) who will be assigned to work only within the dedicated area, when in use." The policy also states, "Move resident to COVID-19 designated area if test results are positive for SARS-CoV2."

The Floor Plan dated "8/16/20 Original" documents R17 and R27 are roommates, R19 and R23 are roommates, R16 and R6 are

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roommates, R20 and R26 are roommates, R21 and R25 are roommates, and R22 and R24 are roommates.

On 9/4/20 at 12:50 PM V1 (Administrator) confirmed the floor plan dated "8/16/20 Original" documents resident room assignments through the morning of 8/18/20.

The Nurses Note dated 8/14/20 documents R17 has a temperature of 102 degrees Fahrenheit and that R17 was placed on droplet precautions. The Nurses Note dated 8/14/20 at 5:20 PM documents R17's Rapid COVID-19 test is positive. R17's Nurses Notes dated 8/14/20 through 8/16/20 do not document R17 was moved to a COVID-19 Unit or that R17 or R17's roommate R27 were moved to different rooms.

R27's (R17's Roommate) Nurses Notes dated 8/14/20 at 5:45 PM document a rapid COVID-19 test was collected for R27 and R27's rapid COVID-19 test was negative. R27's Nurses Notes dated 8/14/20 through 8/16/20 do not document R27 was moved to a different room away from R17. R27's Nurses Notes and vital signs records dated 8/13/20 and 8/14/20 do not document R27 has signs or symptoms of COVID-19.

The Nasopharyngeal Swab test results dated as collected 8/16/20 and reported 8/17/20 document R16, R19, R17, R22, R20, R21 and R27 are positive for SARS-CoV-2.

The Nasopharyngeal Swab test results dated as collected 8/16/20 and reported 8/17/20 document R6, R23, R24, R25 and R26 are negative for SARS-CoV-2. R6, R23, R24, R25 and R26's nurses' notes and vital signs records dated 8/17/20 and 8/18/20 do not document signs or

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S9999	Continued From page 4 symptoms of COVID-19. The Laboratory Report dated 8/21/20 documents R25 is positive for the SARS-CoV-2 Antigen COVID-19. The Nasopharyngeal Swab test results dated as collected 8/24/20 and reported 8/25/20 document R6, R23, and R26 are positive for SARS-CoV-2. On 9/4/20 at 10:00 AM V18 (Assistant Administrator County Public Health Department) stated R17 had a positive rapid COVID-19 test on 8/14/20. V18 stated according to the floor plans V1 sent to the health department, R17 (who was positive for COVID-19 {antigen} on 8/14/20), was still in the same room with R27 (who was negative for COVID-19 {antigen}, on 8/16/20). V18 stated R17 should have been moved on 8/14/20. On 9/4/20 at 1:30 PM V16 (Registered Nurse) confirmed R17 had a positive rapid COVID-19 test on 8/14/20 and that R17 remained in the same room with R27 all weekend (8/15/20 and 8/16/20). V16 stated R17 went out the Hospital Emergency Department over the weekend and was readmitted back into the same room with R27. On 9/4/20 at 10:00 AM V18 stated health department staff were notified by the facility the morning of 8/18/20 of several additional SARS-CoV-2 positive residents. V18 stated V18 spoke with V1 and V1 wanted to leave SARS-CoV-2 positive residents in the same rooms with SARS-CoV-2 negative residents. V18 stated V18 told V1 that V1 needed to develop a COVID-19 unit for the residents that tested positive and an observation unit for residents who	S9999		

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were exposed. V18 stated when V1 was told V1 would have to create a COVID-19 Unit, V1 was not cooperative. V18 stated around 3:00 PM on 8/18/20 a family member (V20) of a SARS-CoV-2 negative resident (R6) came to the health department and complained that R6 was not going to be moved away from R6's SARS-CoV-2 positive roommate (R16) until the next day. V18 stated V18 assured V20 that V18 spoke to V1 and the residents would be moved today (8/18/20). V18 stated V20 returned to the health department at 5:00 PM on 8/18/20 and reported again that R6 was told by facility staff that the residents would not be moved until the next day. V18 stated V18 called V1 and found that V1 had left the facility for the day without moving the infected residents away from the non-infected residents and without setting up the COVID-19 and Observation Units. V18 stated V1 told V18 that V1 was not going to move the residents or set up the COVID-19 unit until the next day. V18 stated V1 was adamant V1 was not going to move the residents and "it was a challenge to get (V1) to move the residents." V18 stated V1 told V18 that V1 did not have the staff to move residents today (8/18/20) and V1 thought moving the residents would spread the virus throughout the building. V18 stated V1 was "angry and hostile." V18 stated V1 did not want to go back to the facility and move the residents. V18 stated V18 told V1 the residents had to be moved today (8/18/20). V18 stated V18 received a text message from V1 around 6:15 PM that evening stating the residents were being moved.

The electronic mail from V18 dated 9/4/20 documents " I (V18) explained again the need to place the COVID positive residents into a COVID unit immediately. (V1) argued this point, saying (V1) had an algorithm from the CDC (Centers for

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Disease Control and Prevention) that indicated (V1) did not have to separate the positive and negative residents and that (V15) (IDPH Infection Control Consultant) had told (V1's) boss the same thing. I (V18) asked for (V1's) supervisor's contact information (which (V1) refused to give me) and immediately tried to contact (V15)."

On 9/8/20 at 12:00 PM V15 stated V15 did not tell the facility it was ok to leave COVID-19 positive residents and COVID-19 negative residents together. V15 stated it is wrong to leave COVID-19 positive and negative residents together for an extended period of time. V15 stated the facility was ignoring guidance.

On 9/10/20 at 10:30 AM V2 (Director of Nurses and Infection Preventionist) stated they were going by the CDC Algorithm that states to move residents if possible. V2 stated they had no private rooms and thought they could draw the curtain between the COVID-19 positive and negative residents and place the residents on droplet precautions. V2 stated the local public health department "trumped their policy" by telling facility staff they had to move COVID-19 positive residents together and exposed residents together. V2 stated V2 thought V1 spoke to local public health department staff on 8/18/20.

On 9/4/20 at 12:50 PM V1 confirmed the facility received the test results for the positive and negative SARS-CoV-2 residents by fax the morning of 8/18/20 and then V1 left the facility that evening without moving the residents or setting up the COVID-19 Unit. V1 confirmed R16, R19, R22, R21, R20, and R27 tested positive for SARS-CoV-2 on 8/18/20.

On 9/10/20 at 11:05 AM V1 was asked if V1

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S9999	Continued From page 7 called the local health department to report the positive COVID-19 test results on 8/18/20, and V1 stated "they called me, or I called them. I don't remember." V1 was asked what instructions V1 was given by the local health department on 8/18/20 and V1 stated, "I don't recall, I don't want to say if I don't remember." On 9/4/20 at 10:00 AM V18 stated the facility started with 4-6 cases and then left SARS-CoV-2 positive residents in rooms with SARS-CoV-2 negative residents for an extended period of time, and the virus spread throughout the building. The Spreadsheet sent by V1 by electronic mail on 9/4/20 documents 32 residents and 17 staff members have tested positive for SARS-CoV-2. The Resident Roster dated 9/1/20 documents 37 residents reside in the facility. (B)	S9999		