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 IL6001770 B. WING 10/07/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **107 NORTH WATKINS STREET CISNE REHABILITATION & HEALTH CENTER CISNE, IL 62823** SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S 000 **Initial Comments** S 000 Focused Infection Control Survey/COVID-19 Focused Survey & Complaint 2157195/IL138693 -F880G cited S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.696a) 300.696c)6)7) 300.1020a) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.696 Infection Control Each facility shall establish and follow Affachment A policies and procedures for investigating. Statement of Licensure Violations controlling, and preventing infections in the

Illinois Department of Public Health

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

TITLE

(X6) DATE

PRINTED: 11/10/2021

**FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED IL6001770 B. WING 10/07/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **107 NORTH WATKINS STREET** CISNE REHABILITATION & HEALTH CENTER **CISNE, IL 62823** 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 DEFICIENCY) S9999 Continued From page 1 S9999 facility. The policies and procedures must be consistent with and include the requirements of the Control of Communicable Diseases Code. and the Control of Sexually Transmissible Infections Code. Each facility shall monitor activities to ensure that these policies and procedures are followed. Each facility shall adhere to the following guidelines and toolkits of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, and Agency for Healthcare Research and Quality (see Section 300.340): Guideline for Isolation Precautions: Transmission of Infectious Agents in Healthcare Settings Guideline for Infection Control in Healthcare Personnel Section 300.1020 Communicable Disease **Policies** a) The facility shall comply with the Control of Communicable Diseases Code (77 III. Adm. Code 690). Section 300.1210 General Requirements for Nursing and Personal Care 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

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each resident's comprehensive resident care

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 IL6001770 B. WING 10/07/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 107 NORTH WATKINS STREET **CISNEREHABILITATION & HEALTH CENTER CISNE. IL 62823** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 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 Regulations were not met as evidenced Based on observation, interview, and record review the facility failed to 1. Isolate residents displaying symptoms of Covid-19 until a negative test result was obtained. 2. Implement contact and droplet isolation precautions for residents displaying signs and symptoms of Covid-19. 3. Conduct a Covid-19 screening on surveyors entering the facility. These failures have the potential to affect all residents residing in the facility and resulted in R2 contracting Covid-19, experiencing ill effects with evaluation and treatment sought at the local hospital for medication infusion. Findings Include: 1. On 10/5/21 at 8:39 AM, V2 (Director of Nursing) states the current facility census is 26. V2 states that the facility has 3 (R1, R2, R3) current resident Covid-19 cases. V2 states all 3 cases have had a hospital admission or received hospital treatment. V2 states that the facility has 2 (R4, R5) residents residing in the facility who are

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 C B. WING\_ IL6001770 10/07/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **107 NORTH WATKINS STREET CISNE REHABILITATION & HEALTH CENTER CISNE, IL 62823** (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY)

S9999	Continued From page 3	S9999		
6	not vaccinated for Covid-19. V2 states that the facility has no other residents on isolation precautions for any reason other than R1, R2, and R3 who are on precautions for Covid-19.			
	Review of the policy titled, "Facility Testing of Staff and Residents" dated 9/14/20 documents, "Testing of Residents with Covid-19 Symptoms3. Residents with symptoms must be placed on TBP (transmission based precautions) until the test results are received."	€		*8
	Review of an undated article titled "Transmission" published by the CDC and found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Transmission states that, based on existing literature, the incubation period of SARS-CoV2 and other coronaviruses ranges from 2-14 days.			
	On 10/5/21 at 8:39 AM, V2 states the facility recently experienced the start of their current outbreak when a staff member V6 (Certified Nurse Assistant, CNA) tested positive for Covid-19. V2 states at the time she tested positive, the facility was being tested weekly and wearing surgical masks as personal protective equipment (PPE). V2 states V6 had tested negative during her routine test that week, and the next day became ill while at work (9/17/21). A			
:	rapid test was then conducted at that time with a positive result. V2 states V6 was immediately sent home. V2 states after V6 tested positive, the facility implemented N95 grade masks, eye			·
	protection, and twice a week testing for staff and residents. V2 states staff receive rapid testing for Covid-19 and resident tests are sent to a lab. V2 states R1 began displaying respiratory symptoms during the evening on 9/23/21 with V5 (Physician)	z)		V.
	coming to the facility to examine her on 9/24/21.		S€	

PRINTED: 11/10/2021 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. IL6001770 8. WING 10/07/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 107 NORTH WATKINS STREET CISNE REHABILITATION & HEALTH CENTER **CISNE, IL 62823** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S9999 Continued From page 4 S9999 V2 states V5 prescribed antibiotics, treating her for bronchitis. V2 states R2, who had no concerning symptoms, remained in the same room as R1 during the time she was displaying respiratory symptoms, due to not having a positive Covid-19 test on either resident at that time. V2 states their last test results were negative, and the most recent collection results which were obtained on 9/23/21 were not yet available. V2 states after later receiving R1's positive Covid-19 results on 9/26/21, R1 was immediately removed from the room with R2. V2 states R2 was not put on any special quarantine precautions or again tested for Covid-19 because her test for Covid-19 collected 9/23/21 had come back negative. V2 states standard precautions were used, as with any resident. V2 states she was notified by facility staff on 9/29/21 that V4 (Family Member) had called the facility upset. V2 states V4 expressed R2 had been left in the room with R1 while ill, and V4 had called an ambulance to have R2 evaluated at the hospital as R2 had reported to her that she wasn't feeling well. V2 states R2 was transported to the local hospital where she tested positive for Covid-19, received an infusion for Covid treatment, then returned to the facility. On 10/1/21 at 9:15 AM, V3 (Registered Nurse) acknowledges R1 had been displaying a new onset cough which initiated the referral for her to be seen by V5 (Physician) resulting in antibiotics being ordered. Review of the document titled "(Facility) Resident Infection Control and Antimicrobial Log" dated

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"September 2021" documents on 9/24/21, R1 s documented under the column "Infection Related Dx (diagnosis), "Resp. (Respiratory)". Under the column "Isolated Yes/No," No is indicated.

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A "Patient Report" from the local hospital

Review of R2's Hospital Records note on the

documents Covid-19 test results as being positive for R2 when tested at the hospital on 9/29/21.

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daughter on the "I-Pad." R2 is alert and oriented

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well and having respiratory symptoms. V5 states he was under the impression for R1 that the Covid-19 test performed 9/23/21 was a rapid test that was negative. V5 states he was not aware when seeing R1 on 9/24/21 that the results from the 9/23/21 test were pending at that time. V5 states he would expect R1 to have been isolated

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		utilizing surgical ma	sks as personal protective						
		equipment for Covid	1-19 prevention, V2 states no	1					
		I auditional precaution	NS Were implemented for						
		standard precaution c	ontrol after V6 tested positive,						
		standard precautions remained. V2 states the facility has red and green units implemented for		_					
		positive and negative	e Covid residents as						
		instructed by corpora	ate. Due to a lack of space no						
		yellow unit/rooms for	r precautionary Covid-19						
		isolative measures a	are in place.	!	1				
		On 10/5/21 at 11:10	AM, V1 (Administrator)					1	
		slates that V6, who t	ested positive for Covid-10						
		worked all throughou	It the building and was not						
		assigned to a specifi	c area. V1 states the facility						
		is smaller, so staff w	ork everywhere.						1
		Review of lab results	documents that specimens						1
		collected on 9/23/21	with results reported to the						1
		facility on 9/26/21 def	termined R1 and R3 were						1
		positive for Covid-19.							1
		On 10/5/21 at 8:36 A	M, V2 states that R1 and R2						ı
		had been roommates	prior to R1 testing positive						I
		for Covid-19. V2 state	es that R1 began displaying						
		respiratory symptoms	on 9/23/21, also having a						
		that day it was not us	ection for Covid-19 obtained				ŀ		l
		that specimen were re	ntil 9/26/21 that the results of eported as being positive, in						ı
		which at that time R2	was removed from the						ı
		room and placed in is	olation, V2 states that R2						
		was not placed in any	Sort of Covid-19 isolation						
		precaution as her test	also collected on 9/23/21						1
		had been residing with	ive. V2 states although R2						
		isolation measures we	nin close contact of R1, no						
		precautionary measur	e for R1.						
		3. Review of the facility Covid-19 Control Mea	y policy titled "(Facility) sures" revised 4/30/21						

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING IL6001770 10/07/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **107 NORTH WATKINS STREET** CISNE REHABILITATION & HEALTH CENTER **CISNE, IL 62823** 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**) S9999 Continued From page 12 S9999 under section "Monitoring and Surveillance-Employees," " ... 2. Screen all essential consultants, contracted staff upon entrance to the facility. If the facility is in outbreak status, consultants and contracted staff must also be screened every 4 hours. If any are identified as being ill, ask them to return home and contact their employer and primary physician." On 10/1/21 at 8:25 AM, 10/5/21 at 8:16 AM, 10/6/21 at 8:45 AM surveyor 1 was let into the locked front door of the facility by ringing the doorbell, with it being answered by V9 (Housekeeping). No screening process for Covid-19 was conducted. On 10/5/21 at 9:45 AM, 10/6/21 at 10:00 AM surveyor 2 was let into the locked front door of the facility by ringing the doorbell, with it being answered by V1. No screening process for Covid-19 was conducted. On 10/6/21 at 12:00 PM, V1 states that surveyors have not been screened during this survey as he states he was previously instructed that surveyors do not get screened. Aresident Matrix provided by the facility on 10/5/21 documents the facility census as being 26. (A)