FORM APPROVED Illinols Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ С IL6001309 B. WING 07/21/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1414 MILTON ROAD **BURT SHELTERED CARE HOME ALTON, IL 62002 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 CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE **DEFICIENCY**) S 000 **Initial Comments** S 000 Complaint Investigation: 2245216/IL148665 S9999 Final Observations S9999 Statement of Licensure Violations : 330.790 a) 330.790 c)1)3)7)8)9) 330.790)d)1)2) 330.790)e)1)2)A)B)3)A)B)D)4)5) 330.790)f) 330.790)g) 330.794 a)1)2)3) 330.794 b)1)2)A)B)C)3)4)A)B)5)6) 330.794 c)1)2)3)4)5)6)7) 330.794 g) 330.794 h)1)2)3) Section 330.790 Infection Control (Emergency) a) Each facility shall establish and follow policies and procedures for investigating, controlling. preventing, and testing for infections in the facility . The policies and procedures must shall be consistent with and include the requirements of the Control of Communicable Diseases Code and Control of Sexually Transmissible Diseases Code. All staff shall be trained on the policies and procedures, and training records maintained for three years. Activities shall be monitored to ensure that these policies and procedures are followed. Infection control policies and procedures shall be maintained in the facility and made available upon request to facility staff, the resident and the resident's family or resident's representative, the Department, and the certified Attachment A local health Statement of Licensure Violations department.

Illinois Department of Public Health

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

TITLE

(X8) DATE

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 IL6001309 B. WING 07/21/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1414 MILTON ROAD **BURT SHELTERED CARE HOME ALTON. IL 62002** SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) S9999 Continued From page 1 S9999 c) Depending on the services provided by the facility, 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, as applicable (see Section 330.340): 1) Guideline for Hand Hygiene in Health-Care Settinas 3) 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. 7) Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes 8) Interim Guidance for Managing Healthcare Personnel with SARSCoV-2 Infection or Exposure to SARS-CoV-2 9) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic d) Each facility shall conduct testing of residents and staff, including individuals providing services under arrangement and volunteers, for the control or detection of communicable diseases when: 1) The facility is experiencing an outbreak; or 2) Directed by the Department or the certified local health department where the chance of transmission is high, including, but not limited to. regional outbreaks, epidemics, or pandemics e) COVID-19 Testing and Documentation The facility shall test residents and facility staff, which includes any person who is employed by, volunteers for, or is contracted to provide services for a facility, or is employed by an entity that is contracted to provide services to a facility, for COVID-19. At a minimum, the facility shall:

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION		SURVEY
		IL6001309	B. WING	19	C 07/21/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
BURTS	HELTERED CARE HO	4444 8000	TON ROAD		1:#	
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S 9999	Continued From pa	ge 2	S9999	18	<u> </u>	
; ;;;	residents or staff wi 2) If a resident of positive for COVID- or broad-based app	conduct immediate testing of th symptoms of COVID-19; or staff in the facility tests 19, follow either a unit-based roach for testing residents s of vaccination status.	1	.	19 4 3 20	+ô
3	Testing shall include have not tested pos A) If a unit-t facility shall test all r immediately (but no the exposure) in the the staff worked, or	e all residents and staff who itive in the past 90 days. Dased approach is used, the residents and staff t earlier than two days after unit (or department) where the resident resided. Facilities		365 3) 3)		ä
× 5	B) If a broad facility shall test all r immediately (but not the exposure). Facility	t every three to seven days ore positive cases for 14 d-based approach is used, the esidents and facility staff earlier than two days after ties shall continue to test days until there are no more days			£	=
i)	Documentation A) For resident's record any	ents, document in each time a test was completed, of the test, or whether testing	a:	5(4) 54		
	staff member's confi distinct from the staff any time a test was o result of the test, or v or contraindicated;	members, document in each dential medical file (as f member's personnel file) completed, including the whether testing was refused			g ™	94
	report COVID-19 ago National Healthcare of report this data to the the online form availa	that are not required to gregate testing data into the Safety Network (NHSN) shall be Department weekly utilizing able at	19	41	<i>§</i>	
iols Departn ATE FORM	nent of Public Health					×.

PRINTED: 09/25/2022

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DORIGI	TELLENED CARE HO	ALTON, I					
(X4)ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLA (EACH CORRECTIV CROSS-REFERENCEI	N OF CORRECTIC	D RE	(X5) COMPLETE
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	https://app.smartsh	eet com/h/form				t	
	/fa2d7abfb102490b	9d2622a2ba4 90744.	1.	•			
		72	1 1				
	4) Upon confirm	nation that a resident or staff	1 1				
1	member tests positi	ve with COVID-19, or if a	1 1				
(4)	consistent with COV	mber displays symptoms /ID-19, take immediate steps					
- 1	to prevent the trans	mission of COVID-19,] [
ĺ	including but not lim	ited to cohorting, isolation and	[[
- 1	quarantine, environr	mental cleaning and					
	disinfecting, hand hy	giene, and use of appropriate	1 1				
	personal protective	equipment;	[]				
	residents and staff, i services under arrar refuse testing or are	procedures for addressing including individuals providing agement and volunteers, who unable to be tested, ent that all volunteers shall					
	testing laboratory to collected under subs ensure that complete	make arrangements with a process any specimens sections (d) and (e) and information is submitted including name, address, se, and ethnicity.					
	g) Each facility shall under subsections (d Department upon red	keep a record of testing done i) and (e), available to the quest.					
	Section 330.794 CO	VID-19 Vaccination of Facility					
	Staff (Emergency) a) For the purposes of the purpose of the purposes of the purpose of the pu	of this Section: f person" means any person		•			
10	who is employed by,	volunteers for, or is					
	contracted to provide	services for a facility, or is	,				•
	employed by an entity	y that is contracted to					
].	provide services to a	facility, and is in close feet) with other persons in			•		
- 1	nent of Public Health	leet/ with other persons in					

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:		TE SURVEY MPLETED
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DUDTE	HELTERED CARE HO	4444 8801	TON ROAD		115.	
BURISI	TELIERED CARE NO	ALTON, II			*	7.
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	78			1		
Ē.	a regular basis as d	inutes at least once a week on letermined by the facility. The person" does not include any	Ÿ			
5.4	person who is prese	ent at the facility for only a		¥8		
	short period of time	and whose moments of close				
	(e.g., contractors m	o others on-site are fleeting aking deliveries to a site				İ
ĺ	where they remain	physically distanced from				
}	others or briefly enter	ering a site to pick up a		}	19	1
	shipment).					
	COVID-19 that has	accine" means a vaccine for				
	emergency use. lice	ensed, or otherwise approved				100
	by the U.S. Food an	d Drug Administration (FDA).				
]	An individual	is "fully vaccinated against				1
	COVID-19" two wee	ks after receiving the second			1	200
	gose in a two-gose s	series of a COVID-19 vaccine gency use, licensed, or		385		53
1	otherwise approved	by the FDA, or two weeks		1		
J	after receiving a sing	gle-dose COVID-19 vaccine		.0		iii .
	authorized for emerg	gency use, licensed, or		(F)		
=	otherwise approved	by the FDA.				1
505	h) Each facility shall	require all staff to be fully		İ		1 [
3-1	vaccinated against (COVID-19 or be tested in a				
	manner consistent w	vith the requirements of		<u>□</u>		
İ	subsection (c).					i I
12	1) New facility st	aff shall receive or have		4P		
88	two-dose vaccine se	um, the first dose of a ries or a single dose vaccine		*		i I
92	no later than 10 days	s after their start date at the		*		! !
	facility, and if applica	ble, the second dose of a		## · · · · · · · · · · · · · · · · · ·		1
	two-dose COVID-19	vaccine series within 30				[
	days after administra	ation of their first dose, or be				ļ
	tested consistent wit subsection (c).	h the requirements of			-	
		hall require staff who are fully				
	vaccinated against C	COVID 19 to submit proof of lest COVID-19. Proof of		Ø tel		
	THESTICATE IT ASKIII	JUN 1001 U				

AND PLAN	NTOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE COM	SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		- 112022
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		ALTON, IL	62002			
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3.6	one of the following A) A Center Prevention (CDC) C card or photo of the	s for Disease Control and COVID-19 vaccination record card;		S		
ļ	health care provider or C) State imp	ntation of vaccination from a or electronic health record;			10	3) 4
į	opportunities for sta against COVID-19, indirectly, such as the pharmacy partner, to other appropriate he				8 4 85	is a
	members from the refully vaccinated again A) Vaccination contraindicated, included member who is entitle under the Americans other law appliable to reasonable accommender and the commender that is a possible to	on is medically uding any individual staff tled to an accommodation s with Disabilities Act or any o a disability-related codation; or				× **
	individual staff memi sincerely held religio observance. 5) Staff that fall v subsection (b)(4) sharequirements set for 6) Facilities may policies requiring all Nothing in the Section	on would require the ber to violate or forgo a us belief, practice, or within the exemption in all undergo the testing th in subsection (c). adopt more stringent staff to be vaccinated. On supersedes or modifies the e designated by the facility to			<i>j</i> e	
	c) Except as provide facility shall require it vaccinated against C	d in subsection (c)(7), each				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION IN MINER		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
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		IL6001309	B. WING	₩ 4 0 .00		C .
NAMEOF	CONTROL OF CHEST ISS				<u> </u>	7/21/2022
NAME OF	PROVIDER OR SUPPLIER			, STATE, ZIP CODE		
BURTS	HELTERED CARE HO!	71E	TON ROAD			
	0.000.00	ALTON, IL	82002	9±%		
(X4) ID PREFIX TAG	(EACH DEFICIENCY)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE	(X5) COMPLETE DATE
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3333	for COVID-19, week are not fully vaccina not tested as require be permitted to enter 1) The COVID-1 Emergency Use Autoperated pursuant to Test requirements of Medicare and Me	cty, at a minimum. Staff who ted against COVID-19 and ed by this subsection shall not er or work at the facility. 19 test shall either have horization by the FDA or be to the Laboratory Developed of the U.S. Centers for eaid Services. aff who are not fully COVID-19 must be conducted or the facility must obtain a from the staff member of a obtained elsewhere. RT-PCR test is the preferred	S9999			£2. ★E
	staff and equipment, minimum, a Clinical Amendments (CLIA) 4) If a staff persoc COVID-19, the facilit person from the facilit person from the facilit be subject to all appl quarantine rules and 5) In the event C antigen testing is not athome or self-tests verified by a health cas required in subsection 6) Staff who are repermitted to enter or are waiting to receive test. 7) When the facility high or substantial tratte CDC COVID 19 In available at	the facility must have, at a Laboratory Improvement Certificate of Waiver. On tests positive for y shall exclude the staff ity, and the staff person shall icable isolation and facility policies. OVID-19 RT-PCR or POC available, staff may use if the tests are observed and are provider, and reportable				* (2) (5) (6) (7) (7) (7) (7) (7) (7) (7) (7) (7) (7

Illinois Department of Public Health

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	NTOF DEFICIENCIES 1 OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION 3:		E SURVEY	_
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NAMEOF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	011	12022	_
BURT SI	HELTERED CARE HO	ME 1414 MIL ALTON, I	TON ROAD L 62002				
(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 CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	DRE COMPLE		
S9999	Continued From pa	ge 7	S9999			 	-
	fully vaccinated aga testing for COVID-1 administered at leas the county in which	I require its staff who are not inst COVID-19 to undergo 9, twice weekly, with tests at two days apart as long as the facility is located remains tial transmission status.				\$ # #	
# # # * * * * * * * * * * * * * * * * *	vaccinated staff, untesting. Facilities that COVID-19 aggregate into the National He (NHSN) shall report weekly utilizing the country and the country was staff.	maintain a record of fully vaccinated staff, and weekly at are not required to report to vaccination and testing data althcare Safety Network this data to the Department online form available at set.com/b/form/fa2d7abfb1020744.	## 	£		TET	
2	each staff person's caccordance with fed regarding COVID-19 including the followin 1) Proof of vacci 2) The results of staff person; and	nation for the staff person; COVID-19 tests for each ation of the vaccination if	製	## 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	27	E.j.	
	by: Based on interview, or review, the facility fai COVID-19, document testing and vaccination to the State Public Health to previous interests to the State Public Health to previous interests to the State Public Health to previous interests to the State Public Health to previous interests to the State Public Health to previous interests to the State Public Health to previous interests to the State Public Health to previous interests to the State Public Health to previous interests the state Public Health Health to previous interests the state Public Health Hea	bbservation and record led to test twice weekly for and report twice weekly on status of employees and of Illinois Department of ent/control the spread of potential to affect all 19 facility.	AV pt		eli:		
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Illinois Department of Public Health STATE FORM

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	E SURVEY PLETED	
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NAMEOF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, 8	STATE, ZIP CODE	 - 112022	
BURTS	HELTERED CARE HO		TON ROAD			
		ALTON, I	L 62002			
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	Findings include:	,				
	1. R1's undated Fac years old.	e Sheet, documents R1 is 58				
	On 7/21/2022 at 10:	25 AM, R1 lay in bed with his			,	
	eyes open. R1 did n	ot respond to the IDPH				
	surveyor's questions vaccination status.	regarding COVID-19		•		
	R1's Physicians Ord 2022, documented h on 3/26/2019.	er Sheet (POS), dated July se was admitted to the facility		•		
	"his family reported s	dated 8/19/2021, documents the has the covid virus. rantined for 10 days."				
1	time. He continues to watching reruns of (7)	dated 8/23/2021, remains the same at this isolate himself in his room rade name), playing (Trade rd puzzles. He will joke				
- 1	R1's Progress Note, o "resident is out of qua signs or symptoms of	dated 8/30/2021, documents arantine, he did not show any f COVID."		. *		
	R1's COVID-19 Vacci	ination Record documented	ĺ		i	
	that he received Mod	erna vaccine on 1/15/2021	}			
	ine second dose was honster dated 12/2/2/	dated 2/16/2021 and the 021. No second booster was			'	
	documented. There w	as no documentation in his				
1	medical record that he had facility for COVID	e was tested at any time in				
	On 7/21/2022 at 12:1	5 PM, V1 (Owner) stated				
⊢ F	R1's family took him o	out of the facility for a haircut				
(date unknown) and h	is family called the next day				

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	NTOF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG:	(X3) DAT	E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY	, STATE, ZIP CODE		21/2022
BURTS	HELTERED CARE HO	4444 BBIT	TON ROAD			
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S9999	Continued From pa	ge 9	S9999			
	quarantined R1 for for COVID-19 becan any COVID-19 tests already received his	positive for COVID-19. V1 10 days, she did not test him use the facility did not have at that time and R1 had first and second vaccination that time. R1 did not have any 0-19.				
	2. R2's undated Fac	e Sheet,R2 is 66 years old.				
	he had 3 COVID-19 another booster, but	40 AM, R2 stated he recalled shots and would take to staff have offered it to all if he was ever tested for				
70 20	that he received Mod the second dose wa booster dated 12/2/2 documented. There	cination Record documented derna vaccine on 1/15/2021, s dated 2/16/2021 and the 2021. No second booster was was no documentation in his ne was tested at any time in 0-19.				
	3. R3's undated Face	e Sheet, R3 is 64 years old.		k ⊕ % •		
	his COVID-19 vaccir was not offered the s	5 AM R3 stated he has had lation and first booster. He second booster yet but would l. R3 stated he could not or COVID-19.	*			
	he received Moderna second dose was dai booster dated 12/2/2 documented. There	ination Record documented vaccine on 1/15/2021, the ted 2/16/2021 and the 021. No second booster was was no documentation in his in was tested any time in the				

NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION			SURVEY PLETED	
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PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, S	TATE, ZIP CODE				
HELTERED CARE HO	M C.			37			
(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH COR	RECTIVE ACTION SH	(OULE) BE	(X5) COMPLETE DATE	
4. On 7/21/2022 at Aide (CNA) Supervi December 2021. Vhad COVID she did	9:00 AM, V2 (Certified Nurse sor) stated she had COVID in 2 stated since she already n't need to have a vaccination	S9999	12 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	459	1 ,2		
stated he was unvace COVID symptoms of temperature taken practifity. V4 didn't give get the COVID vacco COVID vaccination of because he didn't kn	ccinated and completes a heck list and gets his prior to every shift at the e a reason why he refused to ination. V4 didn't know what a exemption was and said now what an exemption was.	# # #	9	** ** _{**}	50 04 12 20		
list and temperature showed no COVID of	Binder, dated 7/21/2022 heck list or temperature		: #1	20	at *	50	
stated she was not vidin't have a reason didn't have an exem COVID-19 symptom temperature checker every day. She didn't unvaccinated and steemption. V3 recall	for not being vaccinated and ption. She completes the check list and gets her d before she starts her shift t give a reason for being ated she didn't have an ed they stopped testing staff	*	· ·		Ē4	at Se	
"shelter homes are to care facilities, and no COVID-19 including residents, how to rep second booster was residents would be e	he stepchild of long-term of one gave them guidance for when to test staff and port the testing, and when the available, and which				94		
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa 4. On 7/21/2022 at s Aide (CNA) Supervi December 2021. V had COVID she did for it. V2 didn't have didn't need one. 5. On 7/21/2022 at stated he was unvacionated and state the was certain he didn't kink he was certain he didn't have a reason didn't have a reason didn't have an exem COVID-19 symptom temperature checked every day. She didn't unvaccinated and state exemption. V3 recall and resident for COVID-19 including residents, how to repsecond booster was	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 4. On 7/21/2022 at 9:00 AM, V2 (Certified Nurse Aide (CNA) Supervisor) stated she had COVID in December 2021. V2 stated since she already had COVID she didn't need to have a vaccination for it. V2 didn't have an exemption and stated she didn't need one. 5. On 7/21/2022 at 11:00 AM, V4 (Maintenance) stated he was unvaccinated and completes a COVID symptoms check list and gets his temperature taken prior to every shift at the facility. V4 didn't give a reason why he refused to get the COVID vaccination. V4 didn't know what a COVID vaccination exemption was and said because he didn't know what an exemption was, he was certain he didn't have one. Review of the facility's Staff Daily COVID Check list and temperature Binder, dated 7/21/2022 showed no COVID check list or temperature documented for V4. 6. On 7/21/2021 at 11:30 AM, V3 (Housekeeper) stated she was not vaccinated for COVID. She didn't have a reason for not being vaccinated and didn't have an exemption. She completes the COVID-19 symptom check list and gets her temperature checked before she starts her shift every day. She didn't give a reason for being unvaccinated and stated she didn't have an exemption. V3 recalled they stopped testing staff and resident for COVID-19 in December 2021. 7. On 7/21/2022 at 9:35 AM, V1 (Owner) stated "shelter homes are the stepchild of long-term care facilities, and no one gave them guidance for COVID-19 Including when to test staff and when the second booster was available, and which residents would be eligible for it. She called the	ILEGOTION IDENTIFICATION NUMBER: ILEGOTION ILEGOTION NUMBER: ILEGOTION NUMBER ILEGOTION NUMBER: ILEGOTION NUMBER: ILEGOTION NUMBER: ILEGOT	IL6001309 IL6001309 STREET ADDRESS, CITY, STATE, ZIP CODE ALTON, IL 62002 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A. On 7/21/2022 at 9:00 AM, V2 (Certified Nurse Aide (CNA) Supervisor) stated she had COVID in December 2021. V2 stated since she already had COVID she didn't need to have a vaccination for it. V2 didn't have an exemption and stated she didn't need one. 5. On 7/21/2022 at 11:00 AM, V4 (Maintenance) stated he was unvaccinated and completes a COVID symptoms check list and gets his temperature taken prior to every shift at the facility. V4 didn't give a reason why he refused to get the COVID vaccination. V4 didn't know what a COVID vaccination exemption was and said because he didn't know what an exemption was, he was certain he didn't have one. Review of the facility's Staff Daily COVID Check list and temperature Binder, dated 7/21/2022 showed no COVID check list or temperature documented for V4. 6. On 7/21/2021 at 11:30 AM, V3 (Housekeeper) stated she was not vaccinated for COVID. She didn't have a reason for not being vaccinated and didn't have an exemption. She completes the COVID-19 symptom check list and gets her temperature checked before she starts her shift every day. She didn't give a reason for being unvaccinated and stated she didn't have an exemption. V3 recalled they stopped testing staff and resident for COVID-19 in December 2021. 7. On 7/21/2022 at 9:35 AM, V1 (Owner) stated "shelter homes are the stepchild of long-term care facilities, and no one gave them guidance for COVID-19 including when to test staff and residents, how to report the testing, and when the second booster was available, and which residents would be eligible for it. She called the	DENTIFICATION NUMBER B. WING	IL6001309 B. WING DENTIFICATION NUMBER B. WING DOTE	

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	Madison County He them for COVID-19 the outbreak, but he on deaf ears. No or health department a don't have money to testing kits weekly. the updated guidantshe wasn't aware slunvaccinated staff to V1 didn't have a list any exemptions for top of her head she unvaccinated staff. COVID-19 symptom temperature taken pforms are kept in the and temperature bin	palth Department and begged tests and for support during or calls and concerns landed he called her back from the and this is a small facility, we be purchasing COVID-19 V1 stated she didn't receive ce dated 3/22/2022 and said he should be testing wice a week and reporting it. of staff vaccination status or the unvaccinated staff, off the stated there were 3 Unvaccinated staff complete a his check list and get the prior to working their shift, the estaff daily COVID check list and covid the					
	temperature Binder V4, V6 and V7 comp symptom check list. These staff refused but no exemptions will document tested weekly or twic documentation on fil vaccination status to Public Health (IDPH. The Centers for Dise "https://covid.cdc.go.documented that from V4, V6, V6, V6, V6, V7, V6, V7, V7, V7, V7, V7, V7, V7, V7, V7, V7	the COVID-19 vaccination, vere documented. The facility entation of employees being se a week nor did they have e of reporting results or the Illinois Department of) ase Control (CDC) website, v/covid-data-tracker/index." m 7/6/2022 to 7/12/2022 the ssion rate was high for the					

The State of Illinois, Illinois Department of Public linois Department of Public Health

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING IL6001309 07/21/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1414 MILTON ROAD **BURT SHELTERED CARE HOME ALTON. IL 62002** 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) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) S9999 Continued From page 12 S9999 Health, "Updated Interim Guidance for Nursing Home and Other Licensed Long-Term Care Facilities", dated 03/22/2022, documented, "Reporting of Staff and Resident COVID-19 Vaccinations and Testing. Facilities that are not required to report COVID-19 aggregate vaccination and testing data into the National Healthcare Safety Network (NHSN) shall report this data to IDPH weekly utilizing the online form at LTC Weekly Reporting COVID-19 Vaccinations and Testing. The required information matches that submitted by CMS-certified facilities to NHSN." It continues, "For those residents not suspected to have COVID-19, (Health Care Professionals) should use community transmission levels to determine the appropriate (Personal Protection Equipment) to wear. When community transmission levels are substantial or high: At a minimum, HCP must always wear a well-fitted mask and eve protection while present in resident care areas. Facilities might consider always having (Health Care Professionals) wear N95 respirators while in the facility. (Health Care Professionals) are not required to wear eve protection for COVID-19 when working in non-resident care areas (e.g., offices, main kitchens, maintenance areas) when there are substantial or high community COVID-19 transmission levels. HCP should wear eye protection when entering the resident care areas. It continues, "In accordance with Executive Order 2021-22 and per the most recent emergency rules (77 III. Admin Code Sections 295,4047. 330.794, 370.4, and 380.643), assisted living and shared housing facilities, sheltered care facilities, community living facilities, and SMRFs must test staff who are not fully vaccinated at a minimum of weekly or twice weekly based on the community transmission level. (See Table 2)."

Illinois Department of Public Health

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