| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000434 | A. BUILDING: _____ B. WING _____ | 01/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLURE OF GALESBURG | 1145 FRANK STREET GALESBURG, IL 61401 |

| (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 |
|---|---|---|---|---|
| S 000 | Initial Comments<br><br>Annual Certification Survey | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610c)2<br>300.696a)<br>300.696b)<br>300.696c)6<br>300.696c)7<br>300.1210b)<br>300.2210a)<br>300.2210b)2<br><br>Section 300.610 Resident Care Policies<br>c) The written policies shall include, at a minimum the following provisions:<br>2) Resident care services, including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic services (including laboratory and x-ray);<br><br>Section 300.696 Infection Control<br><br>a) Each facility shall establish and follow policies and procedures for investigating, controlling, and preventing infections in the 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. | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000434 | A. BUILDING: _____ B. WING _____ | 01/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLURE OF GALESBURG | 1145 FRANK STREET GALESBURG, IL 61401 |

| (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 | Continued From page 1<br><br>b) A group, i.e., an infection control committee, quality assurance committee, or other facility entity, shall periodically review the results of investigations and activities to control infections.<br><br>c) 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<br><br>6) Guideline for Isolation Precautions: Transmission of Infectious Agents in Healthcare Settings<br><br>7) Guideline for Infection Control in Healthcare Personnel<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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.<br><br>Section 300.2210 Maintenance<br><br>a) Every facility shall have an effective written plan for maintenance, including sufficient staff, appropriate equipment, and adequate supplies.<br><br>b) Each facility shall: | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000434 | A. BUILDING: _____ B. WING _____ | 01/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLURE OF GALESBURG | 1145 FRANK STREET GALESBURG, IL 61401 |

| (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 | Continued From page 2<br>2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems.<br><br>These requirements were not met as evidenced by:<br><br>1. Based on observation, interview and record review the facility failed to place the COVID-19 positive residents and the exposed roommates on transmission based precautions, failed to ensure staff wore required PPE (Personal Protective Equipment) with direct care during a COVID-19 outbreak, failed to place COVID positive residents in a dedicated COVID unit with dedicated staff, failed to ensure required infection control signage was on COVID positive resident doors, failed to keep the door closed for a resident with COVID-19, including a resident receiving aerosolized oxygen via tracheostomy mask on droplet isolation precautions, failed to ensure the chemical dishwasher was functioning according to manufacturer's recommendations, and failed to utilize disposal tableware for residents on transmission based precautions. These failures resulted in the facility having a widespread COVID 19 infection outbreak with 79 residents becoming infected with COVID 19 and two residents of those 79 residents, being hospitalized for treatment of COVID 19, and leaving 14 additional residents who reside on different halls of the facility at risk for exposure to COVID 19. These failures have the potential to affect all 92 residents residing in the facility.<br><br>Findings include:<br><br>The Facility's Infection Control Policy and | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000434 | A. BUILDING: _____ B. WING _____ | 01/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLURE OF GALESBURG | 1145 FRANK STREET GALESBURG, IL 61401 |

| (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 | Continued From page 3<br><br>Procedure for COVID-19 Facility Response Strategy revised 1/21/2022 documented the following: "Universal PPE (Personal Protective Equipment) If a resident is suspected or confirmed to have COVID-19, or is an unvaccinated resident identified to be close contact, HCP (Health Care Personnel) must wear and N95 respirator, eye protection, gown, and gloves. When community transmission levels are substantial or high (HCP) must wear a well-fitted mask and eye protection. This same policy documents the following under the section titled, Management of Residents with Confirmed COVID-19; Resident placement-single room, door closed (if safe to do so), designate a separate area or unit as a COVID-19 unit, isolate using transmission-based precautions, monitor the resident every four hours, dedicate HCP to the COVID-19 unit if possible (including environmental services or housekeeping staff), staff wear full PPE (N95 respirator, gown, gloves, eye protection); communal dining-not allowed in communal areas. Dining should occur in resident room. Group activities-resident should not participate in group activities until recovered.<br><br>On 1/23/22 at 7:45 a.m. upon entrance to the facility a warning sign was posted on the door that the facility had COVID-19 positive cases in the facility.<br><br>On 1/23/22 at 8:05 a.m. a tour of the facility was conducted and there was no dedicated COVID-19 unit set up in the facility.<br><br>On 1/23/22 at 8:30 a.m. V1 (Administrator) provided a facility room roster highlighting seven residents (R9, R19, R59, R65, R76, R80, R81) that are positive for COVID-19 at this time. V1 stated the facility does not have a COVID-19 unit. | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000434 | A. BUILDING: _____ B. WING _____ | 01/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLURE OF GALESBURG | 1145 FRANK STREET GALESBURG, IL 61401 |

| (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 | Continued From page 4<br>V1 stated the seven positive residents reside on three different halls throughout the facility.<br><br>On 1/23/22 and 1/24/22, during the noon meal hall tray pass, the residents on transmission-based precautions were served their meal on regular tableware and not disposable tableware.<br><br>On 1/23/2022-1/25/2022 from 8:30 am-3:00 pm residents were observed in group activities, communal dining and/or socializing without social distancing and some residents without wearing masks.<br><br>On 1/23/22 at 9:00 a.m., R9 and R80's room door had a droplet isolation warning sign posted, oxygen in use sign on the door, and the door was wide open.<br><br>On 1/23/22 at 9:02 a.m., R9 stood up and walked towards the door within approximately three feet of the door to the hallway and entered the bathroom independently.<br><br>On 1/23/22 at 9:05 a.m., R80 had a tracheostomy with a blue corrugated tube running to a machine on the over bed table. R80 coughed numerous times during this observation.<br><br>R80's current computerized Physician Orders, documents to administer Oxygen 6 liters per minute with 35% aerosol per trach mask.<br><br>On 1/23/22 at 7:45 A.M., V6/Licensed Practical Nurse (LPN) was sitting at the facility's main Nurse's Station, located adjacent to the Main Dining room. Seven residents were present, at tables, in the Dining Room. V6/LPN wore only a surgical mask. V6/LPN did not have an N-95 | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000434 | A. BUILDING: _____ B. WING _____ | 01/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLURE OF GALESBURG | 1145 FRANK STREET GALESBURG, IL 61401 |

| (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 | Continued From page 5 | S9999 | | |

mask or a face shield on. When asked, V6/LPN stated, "We currently have COVID positive residents in our building."

On 1/23/2022 at 8:15 A.M., V7/Activity Assistant (AA) was passing breakfast trays on the facility E-Hall wing. V7/AA wore an N-95 mask. V7/AA did not have a face shield on. V7/AA entered R59 and R76's room without performing hand hygiene prior to entering the room or prior to exiting the room.

On 1/23/22 at 10:00 am., R19 was in his room with his roommate (R65). R19 stated, "(R65) had infection (COVID-19) a while back and (I) was asked to move out of the room and (I) told staff (I) did not want to move so they left me in here. (I) now have the infection." R19's door was open with no isolation sign on the door with staff and residents having to pass by the open room to enter B hall and to enter C hall. R19's room is located at the entrance of B hall and has to be passed to enter C hall.

On 1/24/22 at 9;30 am., R19's room door was wide open with R19 sitting in his wheelchair next to the doorway without a mask. R19 can propel himself. At this time residents from B and C hall, and staff were walking by R19's room heading towards and or out of the dining room.

On 1/24/22 at 9:43am., V4 (CNA/Certified Nursing Assistant) was in the dining room talking to R73. V4 was not wearing any face shield/goggles at this time. At 9:47am., V4 was still talking to R73 without her face shield or goggles. At this same time R53 was sitting at a table next to R73 with his mask under his nose.

On 1/24/22 at 9:50am., V5/CNA was walking

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000434 | A. BUILDING: _____ B. WING _____ | 01/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLURE OF GALESBURG | 1145 FRANK STREET GALESBURG, IL 61401 |

| (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 | Continued From page 6 | S9999 | | |

down one of the halls from the breakroom. V5 did not have a face shield, or any goggles on at this time. V5 stated, "(I) have my goggles up front, but the building is clear of COVID at this minute anyway and (I) have been vaccinated."

On 1/25/22 at 9:00 am., V15/Activity Director was standing at the nurse's desk in the dining room with several staff and residents with no goggles on. V15 stated, "(I) should have had my goggles on."

On 1/24/2022 at 12:40 pm V34, CNA (Certified Nursing Assistant) was in the dining room standing at the serving window with her eye goggles situated on the top of her head. V34, then proceeded to walk from the dining room down C Hall with her eye goggles still on the top of her head.

On 1/23/22 at 8:15 a.m., V3, Licensed Practical Nurse stated he was in charge of part of B Hall and all of C Hall. V3 stated that the only resident that was still on COVID-19 isolation was R81.

On 1/23/22 at 9:00 a.m., V3, Licensed Practical Nurse stated, "I was wrong about the residents that I have on isolation." V3 stated in addition to the one I already told you (R81), R9 and R80 share a room and are still in isolation for COVID-19 diagnoses.

On 1/24/22 at 9:43am., V4 stated she just returned from break and her goggles were on C-hall (where she is scheduled to work) and she will put them on when she gets back to that hall. V4 verified she has to walk through B-hall to enter C-hall past R19's room. (COVID Positive Resident).

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000434 | A. BUILDING: _____ B. WING _____ | 01/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLURE OF GALESBURG | 1145 FRANK STREET GALESBURG, IL 61401 |

| (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 | Continued From page 7<br><br>On 1/24/2022 at 10:25 am V1, Administrator and V2, ICP (Infection Control Preventionist) were interviewed. V2 stated the first staff to test positive was V13, Dietary Aide who is responsible for preparing desserts and drinks to be served to the residents. V2 stated V13 was PCR (Polymerase Chain Reaction Test) tested on 12/14/2022 and the results came back positive from the lab on 12/16/2022. On our regular testing date 12/21/2022 V12, CNA (Certified Nursing Assistant) was PCR tested for COVID. On 12/23/2022 V12's PCR COVID test results came back positive. On 12/28/2021 V2, ICP stated she rapid COVID tested all the residents on C hall due to V12 being assigned to C Hall. V2 stated she was unsure if V12, CNA went anywhere else in the building during her shift. V2, ICP stated on 12/28/2021 R83 and R90 were PCR (Polymerase Chain Reaction) COVID tested. V2 stated R83's COVID test came back positive on 1/1/2022 and R90's COVID test came back positive on 1/2/2022. V2 stated the facility had a designated COVID hall "in the beginning" but then once The COVID started spreading through the facility they just kept residents in the rooms they were in. V2 stated if a resident had a roommate, they completed a rapid COVID test on them but if they were negative, they still left the roommates together because, "what is the point of moving them, they have already been exposed. V2 stated she was advised not to stop communal dining and activities "per CDC (Center for disease control) guidelines. V2 stated R5, R7, R12, R22, R23, R36, R50-R52, R55, R56, R61, R77 and R346 have not had positive COVID test results. V2 stated the other 79 residents residing in the facility had already contracted COVID-19. V2, ICP stated the facility did not assign dedicated staff to COVID 19 positive residents. V2 stated there are not any residents who are bedfast and that the | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000434 | A. BUILDING: _____ B. WING _____ | 01/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLURE OF GALESBURG | 1145 FRANK STREET GALESBURG, IL 61401 |

| (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 | Continued From page 8 | S9999 | | |

majority of the residents in the facility are ambulatory. V2, stated staff are to wear eye protection and N95 masks if there is any COVID-19 in the facility. V2 stated when caring for COVID-19 residents' staff should wear N95, eye protection, and a gown.

On 1/25/2022 at 2:20 pm V33, LHD (local health department) stated the following: "There have been a lot of discrepancies with the facility's COVID-19 reporting and timing of communication. The only information I have received is from V1, (Administrator) was regarding accepting new admissions while the facility was in a COVID-19 outbreak. V33 stated V2, ICP (Infection control Preventionist) has never contacted V33 regarding COVID-19 outbreak or guidance.

R86's Admission History and Physical Report from the local hospital, dated 1/1/22, documents, "(R86) is a 60-year-old male with a history of being a nursing home resident secondary to Mental Illness, Type 2 Diabetes, Schizophrenia, Chronic Obstructive Pulmonary Disease, and Hypertension who was sent to the emergency room apparently for concern of altered mental status, was found to be septic with a heart rate above 100 and a temperature of 102.8 as well as being COVID positive. Assessment and Plan, Principal Problem: COVID-19. Sepsis secondary to COVID-19 with dehydration and lactic acidosis-Intravenous therapy hydration."

R43's Critical Care New Consultation Note from the local hospital, dated 1/7/22, documents, "(R43) is a 42-year-old male initially admitted for respiratory arrest secondary to COVID-19 and bacterial pneumonia. Plan: Repeat ABG/Arterial Blood Gas in one hour, Propofol and fentanyl for

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000434 | A. BUILDING: _____ B. WING _____ | 01/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLURE OF GALESBURG | 1145 FRANK STREET GALESBURG, IL 61401 |

| (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 | Continued From page 9<br>sedation, Zosyn, Follow-up sputum culture, titrate oxygen to Sp02 (Oxygen saturation) to 88-92%, Trend troponin, Limited Echocardiogram, Decadron 6 mg (milligram) QID (four times daily), Repeat chest X-ray tomorrow."<br><br>On 1/23/2022 at 11:30 A.M., V20/Dietary Services Manager stated, "We don't use disposable serving ware. It's not in our budget."<br><br>The Manufacturer's Recommended booklet, provided by V1/Administrator documents, "Machine Operational Requirements as manufactured by dish machines: Required 50 PPM (parts per million) chlorine."<br><br>On 1/23/2022 at 11:50 A.M., V8/Cook and V11/Dietary Aide were preparing to serve the facility Noon meal. V8/Cook placed the meal on a plastic plate, covered the food with a reusable, plastic dome and placed the plate on an open serving cart. At that time, both staff members stated they do not serve meals on disposable serve wear as instructed by the dietary manager. V8/Cook further stated that the facility did not have disposable serve wear available for use.<br><br>On 1/24/2022 at 8:36 A.M., V9/Dietary Aide was placing soiled breakfast dishes in dishwashing trays and sending them through the facility chemical dishwashing machine. Multiple attempts to check the required parts per million of chemical sanitizer resulted in the chlorine test strip remaining white (no chemical sanitizer being detected.) The unsanitized dishes were then placed on a metal, rolling cart and taken into the facility kitchen. At that time, V3/Dietary Services Manager stated, "We have been having problems with that machine." | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000434 | A. BUILDING: _____ B. WING _____ | 01/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLURE OF GALESBURG | 1145 FRANK STREET GALESBURG, IL 61401 |

| (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 | Continued From page 10<br><br>2. Based on record review and interview the facility failed to follow up on staff and resident COVID-19 (Coronavirus Disease 2019) laboratory (lab) reports within 48 hours once an outbreak of COVID-19 was identified and failed to initiate alternative testing procedures when experiencing a delay in obtaining lab reports to prevent further viral transmission of COVID-19. These failures resulted in COVID-19 positive staff working directly with the residents and residents with COVID-19 not being isolated promptly, causing an outbreak of COVID-19 within the facility. These failures have the potential to affect all 92 residents.<br><br>Findings include:<br><br>The Centers for Medicare and Medicaid Services Interim Final Rule, CMS-3401-IFC, Reference QSO (Quality Safety and Oversight)-20-38-NH (Nursing Home) Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirement Memorandum dated 9-10-21 documents, "This rule establishes LTC Facility Testing Requirements for staff and residents and provides guidance for facilities to meet the new requirements. To enhance efforts to keep COVID-19 from entering and spreading through nursing homes, facilities are required to test residents and staff based on parameters and a frequency set forth by the HHS (Health and Human Services) Secretary. Facilities can meet the testing requirements through the use of rapid point-of-care (POC) diagnostic testing devices or through an arrangement with an offsite laboratory. POC testing is diagnostic testing that is performed at or near the site of resident care. Facilities without the ability to conduct COVID-19 POC testing should have arrangement with a | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000434 | A. BUILDING: _____ B. WING _____ | 01/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLURE OF GALESBURG | 1145 FRANK STREET GALESBURG, IL 61401 |

| (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 | Continued From page 11<br>laboratory to conduct tests with rapid reporting of results (example within 48 hours) should be selected to rapidly inform infection prevention initiatives and limit transmission. If the 48-hour turn-around time cannot be met due to community testing supply shortages, limited access or inability of laboratories to process tests within 48 hours, the facility should have documentation of its efforts to obtain quick turnaround test results with the identified laboratory or laboratories and contact with the local and state health departments."<br>The Facility's Infection Control Policy and Procedure for COVID-19 Facility Response Strategy dated 1-21-22 and the facility's Laboratory Services Agreement with Lifescan Labs (Laboratories) dated 8-24-20 does not include any documentation or policies to address facility COVID-19 testing requirements to ensure quick reporting of results (within 48 hours), and/or measures to implement if COVID-19 test results are not back within 48 hours.<br><br>V8 (Cook), V16 (Activity Aide), V17 (CNA/Certified Nursing Assistant) SARS (Severe Acute Respiratory Syndrome) COVID rt-PCR (reverse transcription-Polymerase Chain Reaction) Detection laboratories (labs) and the facility's COVID-19 Staff Log of COVID-19 positive staff document V8, V16, and V17's labs were collected on 12-31-21. V8, V16, and V17's same labs document V8, V16, and V17's positive COVID results were reported to the facility on 1-7-22 (seven days after collection).<br><br>V4(CNA), V23 (LPN/Licensed Practical Nurse), V22 (LPN), and V25's (Cook) SARS COVID rt-PCR Detection lab and the facility's COVID-19 Staff Log of COVID positive staff document V4, V23, V22 and V25's labs were collected on | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000434 | A. BUILDING: _____ B. WING _____ | 01/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLURE OF GALESBURG | 1145 FRANK STREET GALESBURG, IL 61401 |

| (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 | Continued From page 12<br><br>1-5-22. V4, V23, V22 and V25's same labs document V4, V23, V22, and V25's positive COVID results were reported to the facility on 1-11-22 (six days after collection).<br><br>V28's (Physical Therapy Assistant) SARS COVID rt-PCR Detection lab and the facility's COVID-19 Staff Log of COVID positive staff document V28's labs were collected on 1-7-22. V28's same labs document V28's positive COVID results were reported to the facility on 1-12-22 (five days after collection).<br><br>V20 (Dietary Manager), V21 (RN/Registered Nurse), and V24's (Resident Care Coordinator) SARS COVID rt-PCR Detection lab and the facility's COVID-19 Staff Log of COVID positive staff document V20, V21, and V24's labs were collected on 1-5-22. V20, V21, and V24's same labs document V20, V21, and V24's positive COVID results were reported to the facility on 1-10-22 (five days after collection).<br><br>R83 and R90's SARS COVID rt-PCR Detection labs and facility's resident line listing of COVID positive residents document R83 and R90's labs were collected on 12-28-21. R83's same lab documents R83's positive COVID result was reported to the facility on 1-1-22 (four days after collection), and R90's same lab documents R90's positive COVID result was reported to the facility on 1-2-22 (five days after collection). This same resident line listing documents R83 was isolated for COVID on 1-1-22 and R90 was isolated for COVID on 1-2-22.<br><br>R83's MDS (Minimum Data Set) dated 1-7-22 documents R83 ambulates independently. R90's MDS dated 1-7-22 documents R90 ambulates independently. | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000434 | A. BUILDING: _____ B. WING _____ | 01/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLURE OF GALESBURG | 1145 FRANK STREET GALESBURG, IL 61401 |

| (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 | Continued From page 13<br><br>On 1-26-22 at 1:00 PM V6 (LPN) stated, "(R83) and (R90) ambulate independently. (R83) comes out of his room to smoke several times daily. (R90) conducts her own church service with the residents in the main dining room."<br><br>R26, R28, R64, and R67's SARS COVID rt-PCR Detection labs document R26, R28, R64, and R67's labs were collected on 12-31-21, received by the laboratory (lab) on 1-6-22 (six days after collection), and reported to the facility on 1-7-22 (seven days after collection) that R26, R28, R64, and R67 were positive for COVID. This same resident line listing documents R26, R28, R64, and R67 were not isolated for COVID until 1-7-22.<br><br>R1, R2, R3, R4, R11, R13, R14, R16, R20, R24, R29, R30, R34, R38, R40, R41, R44, R46, R48, R49, R54, R65, R68, R70, R71, R74, R75, R78, and R95's SARS COVID rt-PCR Detection labs and the facility's resident line listing of COVID positive residents document R1, R2, R3, R4, R11, R13, R14, R16, R20, R24, R29, R30, R34, R38, R40, R41, R44, R46, R48, R49, R54, R65, R68, R70, R71, R74, R75, R78, and R95's labs were collected on 1-5-22, and reported to the facility on 1-11-22 (six days after collection) that R1, R2, R3, R4 R11, R13, R14, R16, R20, R24, R29, R30, R34, R38, R40, R41, R44, R46, R48, R49, R54, R65, R68, R70, R71, R74, R75, R78, and R95 were positive for COVID. This same line listing documents R1, R2, R3, R4 R11, R13, R14, R16, R20, R24, R29, R30, R34, R38, R40, R41, R44, R46, R48, R49, R54, R65, R68, R70, R71, R74, R75, R78, and R95 were not isolated for COVID precautions until 1-11-22.<br><br>R6, R8, R9, R33, R35, R42, R57, R58, R69, R76, and R397 SARS COVID rt-PCR Detection labs | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000434 | A. BUILDING: _____ B. WING _____ | 01/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLURE OF GALESBURG | 1145 FRANK STREET GALESBURG, IL 61401 |

| (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 | Continued From page 14 | S9999 | | |

document R6, R8, R9, R33, R35, R42, R57, R58, R69, R76, and R397's labs were collected on 1-7-22 and reported to the facility on 1-12-22 (five days after collection) that R6, R8, R9, R33, R35, R42, R57, R58, R69, R76, and R397 were positive for COVID. This same line listing documents R6, R8, R9, R33, R35, R42, R57, R58, R69, R76, and R397 were not isolated for COVID precautions until 1-12-22.

R60's SARS COVID rt-PCR Detection lab and the facility's resident line listing documents R60's lab was collected on 1-5-22 and reported to the facility on 1-13-22 (eight days after collection) that R60 was positive for COVID. This same line listing documents R60 was not isolated for COVID until 1-13-22.

The Local Health Department's Call Report/Notes dated 1-5-22 document the health department requested a comprehensive line listing of all facility associated cases since the outbreak testing response began from V1 (Administrator).

The Local Health Departments Call Report/Notes dated 1-10-22 document the health department requested a line listing again from V1.

The Local Health Departments Call Report/Notes dated 1-13-22 document the health department still had not received a line listing from V1, and a request was emailed to V1 to provide the health department with a line listing by Friday 1-14-22.

The facility's CMS Resident Census and Conditions of Resident Form 672 dated 1-23-22 and signed by V2 (Infection Preventionist) documents 64 residents ambulate independently.

The facility's Daily Census Log dated 1-23-22

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000434 | A. BUILDING: _____ B. WING _____ | 01/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLURE OF GALESBURG | 1145 FRANK STREET GALESBURG, IL 61401 |

| (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 | Continued From page 15<br>documents 92 residents currently reside within the facility.<br><br>On 1-23-22 at 10:25 AM V2 (Infection Control Preventionist) stated, "The lab has not been getting us our COVID lab results for at least three to seven days after we obtain the test. I did not know the lab was having problems getting the labs processed until 1-7-22. The lab told me that one of their machines was broke down. At that point I only rapid tested residents and staff who had symptoms of COVID. I did not rapid test any other staff or residents and I did not try to get another lab to process COVID labs. I have never spoke to the health department to get guidance on what to do if we are not receiving our COVID-19 lab results within 48 hours. I had enough rapid tests (POC) to test everyone. I am only one person and did not have the time. I did not think about isolating the residents that the positive staff and positive residents would have had direct contact with. I did not isolate these residents until I received a positive COVID test result."<br><br>On 1-24-21 at 11:00 AM V32 (Facility's Lab Account Representative) stated, "The facility knew January second that one of the lab's machines broke down and the facility's COVID-19 results over the next several weeks would be delayed."<br><br>On 1-25-22 at 10:00 AM V2 stated, "I do not believe our facility policies or our lab contract includes policies on what to do if a COVID-19 lab report does not return within 48 hours. I did not know CMS S&C letters even existed regarding testing procedures."<br><br>On 1-25-22 at 1:40 PM V2 stated V4, V8, V16, | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000434 | A. BUILDING: _____ B. WING _____ | 01/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLURE OF GALESBURG | 1145 FRANK STREET GALESBURG, IL 61401 |

| (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 | Continued From page 16<br>V17, V20, V21, V22, V23, V24, V25, and V28 were never quarantined or removed from work for COVID-19 positive results because their positive lab results were not received by the facility until five to six days later after taking their test and these same staff members could have worked all hallways with all resident's while being positive with COVID-19.<br><br>On 1-25-22 at 10:10 AM V1 (Administrator) verified that the facility's infection control policies do not include policies on what to do if a COVID-19 lab report does not return within 48 hours and the facility does not have a contract with the laboratory including an arrangement to obtain rapid COVID-19 lab results. I did not know anything about the CMS S&C letter regarding testing procedures."<br><br>On 1/24/2022 at 10:25 am V2 stated when COVID-19 first started a long time ago it took forever to get results. The facility normally gets test results in 3-7 days and that 7 days is too long and not acceptable to wait for COVID-19 test results. V2 stated the lab was having difficulties and she was unaware of the difficulties until 1/7/2022.<br><br>On 1/25/2021 at 9:20 am V29 (Vice President of Operations) stated the labs for COVID-19 testing have always been seven days behind and are like that in all of his buildings.<br><br>On 1-25-22 at 2:20 PM V33 (Local Health Department Representative) stated, "The facility never did inform the health department that they were not receiving COVID-19 test results timely or ask for guidance on what to do since they were not receiving their test results timely. I did not receive a line listing from the facility that residents | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000434 | A. BUILDING: _____ B. WING _____ | 01/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLURE OF GALESBURG | 1145 FRANK STREET GALESBURG, IL 61401 |

| (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 | Continued From page 17<br>or staff were even positive for COVID-19 until 1-14-22 at 3:27 PM, which was way after the outbreak. If I would have known I would have told the facility to use a private lab or do rapid testing (POC) on everyone while waiting on the results. I have provided the facility with links and contacts to local labs and have sent all the guidance and S&C letters from CMS to the facility, so the facility should have been aware that lab results should be back within 48 hours. We (the health department) were trying to figure out why there was such a huge outbreak of COVID-19 within the facility, and now I know that it was because there was no follow-up with positive COVID-19 labs getting back timely and staff and residents were allowed to have contact with other residents and staff while being positive for COVID-19. I have never once heard from V2 regarding anything to do with the delay in lab results, or regarding anything with the facility's COVID-19 outbreak."<br><br>(A) | S9999 | | |