STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015333	A. BUILDING: _____ B. WING _____	C 05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE FOREST PARK	8200 WEST ROOSEVELT ROAD FOREST PARK, IL 60130

(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 2393255/ IL158908 300.610a) 300.1210d)3) 300.3240a) 2393111/ IL158721- 300.610a) 300.1210d)3) 300.3240a) 2393020/ IL158609- 300.610a) 300.1210d)3) 300.3240a) 2392034/IL157383- 300.610a) 300.1210d)3) 300.3240a) 2391861/IL157173- 300.610a) 300.1210b)5) 300.1210c) 300.1210d)6) 300.3240a) 2391830/IL157114- 300.610a) 300.1210b)4 300.1210d)3) 300.3240a) 2391683/IL156949- 300.610a) 300.1210d)1) 300.3240a) Facility Reported Incident of 1/24/23/IL 156394	S 000	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Final Observations Statement of Licensure Violations: 1 of 4 Violations: 300.610a) 300.1210d)1) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. Section 300.3240 Abuse and Neglect	S9999		

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S9999	Continued From page 2 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 regualtions were not met as evidence by: Based on interview and record review, the facility failed to manage one residents with type one diabetes by failing to get a continuous blood glucose monitoring device and not following physician orders for Lantus. This affected 1 of 3 residents (R3) reviewed for diabetes. This failure resulted in R3 being hospitalized for diabetic ketoacidosis Findings include: R3 was admitted to the facility on 1/25/23 with a diagnosis of type I diabetes and gastroparesis. R3's physician progress note dated 2/21/23 documents: Patient states blood sugar this morning was 55. Requesting a continuous blood glucose device to avoid finger sticks. Ordered from pharmacy. Patient states asymptomatic this morning. R3 physician order sheet dated 2/21/23 documents: order for continuous blood glucose system sensor. R3's medication administration record for February 2023 under Dexcom documents: 9 which indicates other /see nursing note on 2/21/23, 2/22/23, 2/24/23 and 2/25/23. R3's progress note documents continuous glucose device placed on 3/21/23.	S9999		

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S9999	Continued From page 3 On 4/14/23 12:55PM, R3 who was alert and oriented at time of interview said she requested for continuous blood glucose monitoring device because she had one prior to entering the facility. R3 said she was unsure that she could get the device and when she went out on pass back home she got her equipment and brought it back to the facility. R3 said she knows how to change and monitor device and that the blood glucose reading will alert to her phone if too high or low. R3 said she placed it on 3/21/23. On 4/14/23 at 3:53Pm, V18(ADON) said physician's orders are expected to be followed. V18 said facility was trying to get R3's glucose device from pharmacy but there was an issue wih the insurance. V18 presented email communication with the pharmacy dated 3/22/23. There were no other communications presented. On 4/14/23 at 3:10PM, V67(pharmacy) said pharmacy has continuous blood glucose equipment and device but as part of facility contract, the facility would have needed to call and request for item to be sent. There are certain items and medications that default to profile only and will only be sent if specifically requested. V67 said she was unable to access that far back in the system to see if there were any requests made. R3's medication administration record for February 2023 under insulin lantus : inject 34 unit subcutaneously at bedtime. On 2/20/23, 2/21/23 and 2/23/23 documents: 15. 15 indicates no insulin needed. On 2/25/23 documents 3: 3 absent from home. R3'a blood glucose on 2/20/23 at 21:35 78, 2/21/23 at 22:08 95, 2/23/23 at 21:22 95. There were no documented blood glucose readings for R3 from 2/25/23 at 11:22am	S9999		

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S9999	Continued From page 4 was 320 until 2/26/23 at 7:42Am documents: 400. R3's progress note dated 2/25/23 at 10:45: Resident complains of emesis 6-7 times, medication given but not effective, was not able to tolerate her breakfast, latest vitals are blood pressure-115/57, pulse-119, respirations 24, temperature 98.2 Blood sugar 309 mg/dl. Referred to MD, advised to be sent to local hospital, called ambulance for transportation eta given is after 1 hour. R3's local hospital record dated 2/25/23 documents under chief complaint: nauseas and vomiting due to hyperglycemia. Last blood glucose reading documented at 19:08 at 166. There was no documentation of any insulin given during hospital stay. R3's progress note dated 2/25/23 at 23:40 documents: Resident returned to the facility from local hospital in stable condition via stretcher by two EMTs, no signs of distress observed, vitals WNL, no new order given, will continue to monitor. The next progress note was dated 2/26/23 at 23:15 which documents: Writer placed a call to hospital for a follow up and was made aware that the resident was still being evaluated, endorsed to night shift nurse to follow. On 2/27/223 at 23:01 documents: resident admitted for diabetic ketoacidosis. On 4/19/23 at 11:22AM, V18(ADON) said blood sugar should be assessed at time of readmission. On 4/21/23 at 1:41PM, V63(MD) said staff should call to verify if medication like Lantus should be held. V63 said unsure parameters for lantus and if or when it should be held, just base it on the	S9999		

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S9999	Continued From page 5 patient at time of administration and staff should call him to make decision. On 4/21/23 at 4:54PM, V59(Nurse) said a low blood sugar would be less then 100 and we would call the doctor if we held any insulin. V59 was unable to recall R3. R3's 911 report dated 2/26/23 documents: call received at 8:29AM, at patient 8:36AM. Under narrative documents: dispatched for breathing problems. R3 was found alert and confused breathing quickly while sitting in bed. Per staff, R3 was seen yesterday for vomiting and returned last night. This morning, staff noted that R3 breathing quickly. R3 was placed on oxygen by nursing staff. Staff reported patient blood glucose reading was high. Assessment of R3 note tachypnea, warm skin and disorientation. Vital signs heart rate 140, blood pressure 108/68, pulse ox 97 %, respirations 36, and glucose was high. R3's hospital record dated 2/26/23 documents under diagnosis: Type I diabetes with ketoacidosis without coma. Upon arrival glucose above 600. R3's after visit summary from V62(MD) documents: always administer lantus to patient. Not administering basal insulin will result in diabetic ketoacidosis. (A) 2 of 4 Violations: 300.610a) 300.1210b)5)	S9999		

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S9999	Continued From page 6 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.	S9999		

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S9999	Continued From page 7 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. These regulations were not met as evidence by: Based on interview and record review, the facility failed to monitor and supervise the common dining area and failed to follow the Minimum data set for transfers. This affected 2 of 3 residents (R8, R10) reviewed for falls and supervsion. This failure resulted in R8 having an unwitnessed fall sustaining a laceration requiring 4 sutures. Findings include: 1. R8 - R8 was admitted to the facility on 1/11/22 with a diagnosis of hemiplegia affecting left side, history of falling, anxiety disorder and abnormalities of gait and mobility. R8's brief interview for mental status dated 1/17/23 documents a score of 12/15 which indicates moderately impaired. R8's minimum data set dated 1/17/23 under functional status documents: Transfer- how resident moves between surfaces including to or from bed, chair, wheelchair, standing position(excludes bath/toilet) documents a score of 3 under self-performance which indicates extensive assistance- resident involved in the activity, staff provide weight bearing support; under support documents a score of 3 which indicates two person assist. Under balance from surface-to-surface transfer (bed to chair or wheelchair) documents a score of 2- not steady only able to stabilize with staff assistance. R8 fall risk assessment dated 11/10/22 documents: at risk for falls. R8 incident report dated 1/11/23 at 19:05	S9999		

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S9999	Continued From page 8 documents: resident had unwitnessed fall in the dining room. Observed lying on the floor on his side, has lacerated wound and bleeding to left eyebrow. Under resident description: I was trying to get up from wheel chair but I lost my balance. R8's hospital record dated 1/11/23 documents: patient had unwitnessed fall, Patient was found in dining room on the floor by staff. Laceration noted to left eyebrow. Under procedure documents: 3.5 cm laceration to left eyebrow. Suture repair was done with derma bond and close approximation of wounds. On 4/5/23 at 4:24PM, V7(Nurse) said R8 fell on 1/11/23 and she was alerted by another resident that R8 was on the floor. V7 said she was unable to recall if there were any staff in the dining room at the time of fall but dining room is monitored by staff when residents are present. On 4/8/23 at 4:35PM, V8(CNA) said staff monitor dining room area when residents are present. Each staff is assigned every 30 minutes to monitor residents. On 4/14/23 at 3:53PM, V18(ADON) said common dining rooms are monitored by staff when residents are present. V18 said he is unable to recall if any staff were present in the dining room at the time of R8's fall. V18 said that R8 only requires one to one monitoring if presenting with exit seeking behavior. On 4/14/23 at 3:40PM, V43(CNA) said staff are monitoring the dining room when residents are present. V43 said he was not assigned to the dining room at time of R8's incident but assisted the nurse with transferring R8 back to wheelchair.	S9999		

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S9999	Continued From page 9	S9999		

R8's incident report dated 1/24/23 documents: Resident had witnessed fall in his room, the Certified nursing assistant was preparing the residents bed and instructed to stay still on his wheelchair when suddenly fell to the floor as he was trying to stand from his wheelchair, the resident struck his head in the floor. Under resident description: resident stated he did not know what happened. Under action taken: put pressure to stop bleeding on the lacerated wound.

R8 final report dated 2/1/23 documents under occurrence: Resident had a witnessed fall when he suddenly stood up from his wheelchair as the CNA was preparing to transfer him from his wheelchair to his bed at bedtime. Resident stated that he did not know why he self-transferred without waiting for assistance.

R8's hospital record dated 1/24/23 documents: witnessed fall from wheelchair. Patient stood up and lost balance, falling forward into floor, laceration to left eyebrow. 3 cm jagged scar above left mid and lateral eyebrow from last time. Has new depth wound 4cm medial to this with bleeding, depth to muscle. Under procedures documents: laceration repair 4 cm laceration was repaired using 4 x 4.0 nylon suture.

On 4/8/23 at 4:35PM, V8(CNA) said she was assisting R8 to go to bed. R8 was in his wheelchair next to the bed when he suddenly got up and fell hitting his head in the floor, while she was fixing the bed. V8 said no one else was in the room with her at time of incident.

R8's plan of care date initiated 1/12/22 documents chair to bed transfer 1 assist, may require 2 person assist. R8's care plan initiated

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S9999	Continued From page 10 on 5/3/22 revised 2/6/23 documents: I am wanderer related to exit seeking. Impaired safety awareness. Interventions: one to one with staff. R8 is at risk for falls and injuries related to falls. Risk factors: requires assistance with activities of daily living, possible medication side effects, incontinence, stroke, dementia, history of falls. Low back pain, lack of coordination, abnormal gait and posture initiated on 1/11/22 and revised on 2/3/23; interventions dated 1/13/22: assess for altered cognition, decline in safety awareness, assess for pain; physical therapy and occupational therapy to evaluate and treat, orient to environment, observe, report unsafe conditions, interventions dated 1/13/23 therapy to evaluate upon readmission, continue to educate resident to ask for staff assistance, monitor for syncope, assess for pain. 2. R10 - R10 was admitted to the facility on 11/17/22 with a diagnosis of chronic obstructive pulmonary disease, abnormalities of gait and mobility, lack of coordination, type II diabetes, arthritis, and pain in left leg. R10 brief interview for mental status score dated 1/3/23 documents a score of 15/15 which indicates cognitively intact. R10s minimum data set dated 1/3/23 under functional status documents: Transfer- how resident moves between surfaces including to or from bed, chair, wheelchair, standing position(excludes bath/toilet) documents a score of 3 under self-performance which indicates extensive assistance- resident involved in the activity, staff provide weight bearing support; under support documents a score of 3 which indicates two person assist. Under balance from surface-to-surface transfer (bed to chair or wheelchair) documents a score of 2- not steady only able to stabilize without staff assistance.	S9999		

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S9999	Continued From page 11 On 4/6/23 at 11:30AM, R10 who was alert and oriented at time of interview, said staff transferred her without hoyer lift and she fell. R10 said a female staff was going to transfer her to her wheelchair by herself. R10 said she told the staff she needs a hoyer lift but staff did not listen and said they could transfer R10 to the chair by themselves. R10 said she ended up on the floor in pain and was sent to the hospital. R10 said she did not have any serious injuries from fall. On 4/11/23 at 12:18PM, V18(ADON) said they are unable to identify the staff member that was assisting R10 during transfer at time of fall. R10's fall risk dated 1/3/20 documents at risk for falls. R10s incident report dated 2/24/23 documents: Writer was notified by staff after transferring resident to wheelchair her feet started sliding and she slid down; resident description documents: after transferring to my chair I started sliding down. Under mental status documents oriented to place, time , person and situation. R10's physical therapy discharge summary dated 12/31/22 documents: Transfer dependent. Under recommendations: transferring to wheelchair using hoyer. (B) 3 of 4 Violations: 300.610a) 300.1210b)4	S9999		

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S9999	Continued From page 12 300.1210d)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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. Restorative measures shall include, at a minimum, the following procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe,	S9999		

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S9999	Continued From page 13 dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These regulations were not met as evidence by: Based on interview and record review, the facility failed to ensure a resident drank fluid to stay hydrated. This affected 1 of 3 (R4) residents reviewed for hydration. This failure resulted in R4 being hospitalized and treated for hydration with a 1500ml bolus of fluid. Findings include: R4 had the diagnosis of Dementia, hemiplegia and hemiparesis and dysphagia and a lack of coordination. Minimal data set dated 2/6/23 documents; R4 requires extensive assistance with one person physical assist with eating. R4's laboratory results dated 2/21/23 documents BUN 127 (Critical) Reference range 7-28mg/dL.	S9999		

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S9999	Continued From page 14 On 4/19/23 at 10:43, V75 (Certified Nurse Assistant, C.N.A.) said, I did not measure the amount fluid I gave R4. I was instructed to put the amount of fluid the pitcher held. Point of care charting dated February 20/21, 2023 documents: No fluid was given for the day and evening shift. 400 ml was given on the night shift for 2/20/23 and 200ml was given on the night shift on 2/21/23. Emergency Department notes dated 2/21/22 - Chief complaint lab abnormalities. BUN high. R4 had a blood urea nitrogen (BUN) was 127. R4's mouth: mucous membranes dry. R4 endorsed "not feeling well" Fluids were given for dehydration. Sodium chloride 500milliters (mL) and Lactated ringers 1000 Ml *fluid bolus* was infused. Water Pass- Hydration dated 11/28/12 documents: To provide fresh drinking water to residents in a clan and sanitary manner to meet hydration needs. (B) 4 of 4 Violations: 300.610a) 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall	S9999		

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S9999	Continued From page 15 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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) Based on interview and record review the facility failed to implement their Coronavirus (Covid-19) testing policy to prevent or reduce the spread of Covid-19 on the third floor nursing unit. This failure affected 25 of 45 (R16, R18 - R36, and R38- R43) residents reviewed for outbreak testing, and prevention of the spread of Covid-19.	S9999		

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This failure resulted in V55 (nursing aide) testing positive on 3.29.23 the facility failed to follow their policy and test the residents who received direct care from V55 (R16, R19 - R36). The failure resulted in R19- R21 testing positive 13 days later. R18 displaying signs and symptoms of Covid-19 on 4.6.23, the facility failed to immediately isolate and test R18 allowing R18 to go out to the dentist. R18 tested positive on 4.7.23, and R38-R43 all on the same unit testing positive for Covid-19 on 4.10.23and 4.11.23. V46 (nurse) and V47 (cna) provide direct care for R18 and tested Covid positive six days later. The facility also failed to follow their covid infection control policy by not ensuring V47 (cna) was wearing the recommended personal protective equipment when entering a covid positive room. This failure affected 2 of 3 residents (R29, R37) reviewed for PPE use by staff.

Findings Include:
V55 - On 4/20/23 at 3:31pm, V55 (certified nurse aide, C.N.A) said, I tested positive for Covid-19 on 3/29/23. I had body aches and a temperature of 100.4 F. The last scheduled day I worked was 3/28/23. I worked with R16, R19 - R36.

On 4/21/23 at 12:46pm V18 (Assistant Director of Nursing A.D.O.N.) said, we do not have the first or the second test for R19 -R21. We follow our Covid-19 policy.
On 5/2/23 at 10:45am, V1 (Administrator) there was no changes to the current policy after the Immediate Jeopardy. There was an execution issue on following the current policy that led to Immediate Jeopardy. Staff did not follow the policy.

Assignment sheet dated 3/26/23 and 3/28/23 documents V55 had (R16, R19 - R36).

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S9999	Continued From page 17 Covid-19 staff line list dated 3/29/23 documents: V55 was covid positive with headache and cold-like systems. Last day worked 3/28/23. Facility acquired. No rapid point of care testing report was completed on 3/29/23 and 4/1/23 for (R16, R19-R36). Rapid point of care test report dated 4/10/23 documents: R19-R21 tested positive on 4/10/23. Facility Covid testing- Residents and staff revised 10-21-22 documents under testing of staff and residents: testing trigger a newly identified covid positive staff or resident that can identify close contacts. Under staff: test all staff, regardless of vaccination status, that had a higher risk of exposure with a covid 19 positive individual. Under residents: Test all residents regardless of vaccination status that had close contact with a covid-19 positive individual. Under testing trigger: newly identified covid-19 positive staff or resident in the facility that is unable to identify close contacts; under staff- test all staff regardless of vaccination status, facility wide or at a group level if staff assigned to a specific location where the new case occurred (e.g unit, floor or specific area of the facility), Under residents- test all residents, regardless of vaccination status, facility wide or at a group level (e.g unit, floor or other specific area of the facility). Initial outbreak testing: Test #1 immediately (but not earlier than 24 hour after the exposure), Test 2: if the test was negative, test again 48 hours after the first negative test and Test 3: if the second test was negative, again 48 hours after the second negative test. R18 - Nursing note dated 4/6/23 at 07:05AM (7:05AM) documents: R18 observed with loose	S9999		

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cough and not expectorating. No complaint of (c/o) pain. Skin warm/dry (w/d) to touch, Temp. 100.0F. Tylenol 1000mg given. Endorsed to 7-3 nurse to follow up (F/U).

On 4/18/23 at 3:27pm, V46 (nurse) said, I did not test or isolate R18. I would not test R18 for twenty four hours nor would I isolate R18. We don't isolate unless a resident has Covid. I treated the symptoms.

Nursing note dated 4/6/23 documents: R18 returned from appointment with new orders from Endodontist.

Nursing note dated 4/7/23 at 16:11 (4:11PM) documents: Writer observed resident with cough and slight fever of 99.5F, Tylenol and cough medicine given for comfort per NP orders. Rapid covid test performed with positive results.

On 4/21/23 at 11:40am, V18 (A.D.O.N.) said, R18 should have been tested when R18 displayed symptoms. V2 (D.O.N.) said, Covid symptoms are loss of taste or smell, sore throat, cough, fever or loose bowels.

On 5/2/23 at 10:45am, V1 (Administrator) there was no changes to the current policy after the Immediate Jeopardy. There was an execution issue on following the current policy that led to Immediate Jeopardy. Staff did not follow the policy.

Rapid point of care test report dated 4/7/23 documents: R18 was Covid-19 positive.

Covid-19 staff line list dated 4/11/23 documents: V47 was covid positive with cough, fever, body aches, sore throat and cold like symptoms. Last

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day worked 4/9/23. Facility acquired.
Assignment sheet dated 4/9/23 documents: V47 worked with R18 on 4/9/23.
Covid-19 staff line list dated 4/11/23 documents: V47 (cna) was covid positive with headache and sore throat. Last day worked 4/11/23. Facility acquired.
Rapid point of care test report dated 4/10/23 documents: R39-43 tested positive on 4/10/23. R38 tested positive on 4/11/23.

On 4/19/23 at 1:06pm, V47 (cna) was observed coming out of R29 and R37's room with only a surgical mask covering the mouth and nose. On the outside of R29/R37's door was red zone droplet and contact precautions sign which documents: Personal protective equipment (PPE) to be used prior to entering room: N95 or KN95 mask, goggles or face shield, gloves and gown (always). V47 said, I was getting a lunch tray. I should have worn a N95 mask and a gown. V18 (adon) said, V47 should have had on a N95 mask going into a Covid positive room.

R29's physician order sheet dated 4/14/23 documents: strict isolation- droplet and contact for Covid 19 positive until 4/25/23.

R37's physician order sheet dated 4/18/23 documents: strict isolation- droplet and contact for Covid 19 positive until 4/25/23.

Facility Covid testing- Residents and staff revised 10-21-22 documents under testing of symptomatic individuals: Anyone with even mild symptoms of covid-19 regardless of vaccination status should receive a viral test for covid-19 as soon as possible.
According to the centers for Medicare and Medicaid services QSO-20-38-NH revised

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S9999	Continued From page 20 09/23/22 documents: Residents who have signs or symptoms of COVID-19, regardless of vaccination status, must be tested as soon as possible. While test results are pending, residents with signs or symptoms should be placed on transmission-based precautions (TBP) in accordance with CDC guidance. Once test results are obtained, the facility must take the appropriate actions based on the results. Infection Control Interim Covid 19 policy revised 10/31/22 documents: Page 10 - PPE use in red and yellow zone: HCP who enter room if a resident with suspected or confirmed SARS-CoV-2 infection should adhere to standard precaution and use NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves and eye protection (i.e., goggles or face shield that cover the front and sides of the face). (A)	S9999		