Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
74101 2741	or correction.	BENTH TOX TOX TOWNER.	A. BUILDING:						
IL6010367		B. WING		C 01/09/2024					
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
CHATEAU NRSG & REHAB CENTER 7050 MADISON STREET WILLOWBROOK, IL 60521									
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE				
S 000	Initial Comments		S 000						
	Complaint Investiga	ation: 2470066/IL168352							
S9999	Final Observations		S9999						
	Statement of Licensure Violations:								
	300.696f)7)								
	Section 300.696 Inf	fection Prevention and Control							
	f) Infectious Diseas Outbreak Response	e Surveillance Testing and e							
	facility shall report t and manner as pre- number of residents students, and stude	under subsection (f), each to the Department, on a form scribed by the Department, the s, staff members, volunteers, ent interns tested, and the negative, and indeterminate							
	This REQUIREMENT by:	NT was not met as evidenced							
		view and interview, the facility facility's COVID-19 Outbreak e Department.							
		out of 12 residents (R1-R3 and reviewed for COVID-19.							
	The findings include	e:							
	Nursing) and V3 (In Nurse/IP) said the f started in mid-Dece	00 PM, V2 (Director of a fection Preventionist facility's COVID outbreak tember of 2023. They said V24 (PT) reported to the facility on							

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

Electronically Signed

(X6) DATE TITLE 01/22/24

PRINTED: 02/07/2024 FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '			3) DATE SURVEY COMPLETED	
			A. BUILDING:		С		
		IL6010367	B. WING		1	, 9/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
CHATEA	U NRSG & REHAB CI	-NTER	ISON STRE BROOK, IL 6				
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	H CORRECTIVE ACTION SHOULD BE COMPLETE E-REFERENCED TO THE APPROPRIATE DATE		
S9999	Continued From page 1		S9999				
	12/22/2023 that he tested positive for COVID-19 on 12/22/2023. They said they started contact tracing to identified residents exposed to V24 and then the facility started their COVID Outbreak testing on 12/23/2023. They said R1 tested positive for COVID on 12/23/2023 then R1's roommate R10 on 12/24/2023 and 12/28/2023 R6 residing next door to R10's room tested positive. V2 and V3 said they continued to test symptomatic residents on the unit and 12/30/2023 R3 and R7-R9 tested positive and on 1/04/2024 R11 and R12 tested positive. They said they continued to test residents exposed, including R3's roommate R2. V3 said R2 was tested on 1/01/2024, 1/03/2024, and 1/05/2024 and tested negative. V2 continued to say she was also aware of facility staff testing positive for COVID, including V19 (Housekeeper) on 12/26/2023, V11 (Licensed Practical Nurse/LPN) on 12/28/2023, V20 (Housekeeper) on 12/30/2024, and V22 (Dietary Aid) on 1/04/204.						
	said they failed to reoutbreak because the reporting process. report to local and standard for the facility's COVID said the facility's covID said the facility's recover the recovery failed the facility's recovery failed to recovery faile	Administrator) and V2 (DON) eport the facility's COVID hey were not aware of the V2 said she was going to state health departments on he Survey). On 1/09/2024 rse) said the facility reported Outbreak and positive cases ment on 1/08/2024.					
	Disease (COVID-19 5/08/2023, shows the education, surveillad prevention strategies transmission of CO	and Procedure Coronavirus b) with a revised date of the facility will conduct nce and infection control and the set or reduce the risk of VID-19. The facility will follow to bommendations and guidelines					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVE COMPLETED			
		IL6010367	B. WING		01/0	9/2024		
NAME OF PROVIDER OR SUPPLIER CHATEAU NRSG & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 7050 MADISON STREET WILLOWBROOK, IL 60521								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE		
\$9999	in accordance with Control and Preven Department of Publ Department of Publ identification and is cases. The Illinois Department document- Updated Homes Following the Emergency (updated Reporting of Staff a Vaccinations and Tecommunicable dise	the Centers for Disease tion (CDC), the State lic Health and County lic Health to include olation of any suspected ment of Public Health d Interim Guidance for Nursing me End of the Public Health ed 5/25/23), shows 3. and Resident COVID-19 esting, Other forms of ease reporting mandated by and local health departments	\$9999					

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