STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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 Annual Licensure survey. 300.696 b) 300.696 f)1)2)3)B)4) 300.1035a)2) 300.1035d) 300.1640 g) 300.2080 a) 300.2100 300.2930 d)1)A)B)	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 6): 300.696 b) 300.696 f)1)2)3)B)4) Section 300.696 Infection Prevention and Control b) Written policies and procedures for surveillance, investigation, prevention, and control of infectious agents and healthcare-associated infections in the facility shall be established and followed, including for the appropriate use of personal protective equipment as provided in the Centers for Disease Control and Prevention's Guideline for Isolation Precautions, Hospital Respiratory Protection Program Toolkit, and the Occupational Safety and Health Administration's Respiratory Protection Guidance. 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. f) Infectious Disease Surveillance Testing and Outbreak Response	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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 1) The facility shall have a testing plan and response strategy in place to address infectious disease outbreaks. Pursuant to the plan and response strategy, the facility shall test residents and facility staff for infectious diseases listed in Section 690.100 of the Control of Communicable Diseases Code in a manner that is consistent with current guidelines and standards of practice. 2) Each facility shall conduct testing of residents and staff for the control or detection of infectious diseases when: A) The facility is experiencing an outbreak. 3) Documentation B) For facility staff and volunteers, maintain a testing log documenting any time a test was completed, including the result of the test, or whether testing was refused or contraindicated. The testing log shall include all facility staff and volunteers. 4) Upon confirmation that a resident, staff member, volunteer, student, or student intern tests positive with an infectious disease, or displays symptoms consistent with an infectious disease, each facility shall take immediate steps to prevent the transmission by implementing practices that include but are not limited to cohorting, isolation and quarantine, environmental cleaning and disinfecting, hand hygiene, and use of appropriate personal protective equipment. This REQUIREMENT was not met as evidenced by:	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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	S9999		

Based on observation, interview, and record review, the facility failed to implement their infection control and testing policies and procedures during a COVID-19 outbreak. This had the potential to affect all 28 facility residents.

The findings include:

The facility's 11/28/23 entrance form showed 28 residents in the facility.

1. On 11/28/23, there was a sign on the front doors of the facility noting positive COVID cases in the facility. V2 Director of Nursing (DON)/Infection Preventionist (IP), V5 Registered Nurse (RN), V9 Social Services Director (SSD), V11 Certified Nursing Assistant (CNA), V12 CNA, V13 CNA, and V14 CNA were observed on duty performing their job duties of resident care and services in resident care areas.

At 9:13 AM, R2's room door had isolation signage for contact and droplet precautions. There was personal protective equipment (PPE) available outside the room. The contact precaution sign showed to use dedicated or disposable equipment. Clean and disinfect reusable equipment before using on another person. The droplet precaution sign showed to make sure their eyes, nose and mouth were fully covered before room entry and had pictures of a person wearing a face shield or goggles. R2 was not in her room. V6 housekeeping and V7 housekeeping entered R2's room to clean. V6 and V7 did not wear N95 masks, a face shield or goggles. V6 carried an aerosol can of disinfectant and V7 had a spray bottle of cleaner which she sprayed on a rag. V7 swept the floor, exited the room with the broom to retrieve a dustpan from the housekeeping cart and reentered the room to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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	S9999		

sweep debris into the dustpan and re-exited the room to empty it. V7 picked up a clear plastic bag with R2's laundry off the floor in the room. V7 exited the room, dropped the bag on the floor in the hallway, and then picked it back up and placed into a second clear bag and placed it on the cart. V6 mopped R2's floor and exited the room. After removing their gloves, V6 and V7 did not perform hand hygiene or change their surgical masks. V6 and V7 placed the aerosol container, spray bottle, broom, dustpan, and mop back onto the cart without disinfecting them. R2 was observed in the hallway in her wheelchair being assisted by staff to return to her room. R2 had a surgical mask on.

At 9:55 AM, R2 was in her room with her door closed. R2 was not wearing a mask. R2 said she went out for a cigarette earlier. R2 had nasal congestion and sniffling. R2 said she was unhappy she was told this surveyor told "them" her door needed to be shut (this was not true). R2 said before today, her room door had been open since her COVID diagnosis yesterday.

At 1:04 PM, V6 and V7 confirmed they did not disinfect or clean the broom, mop or any other equipment used in R2's room prior to using the same in other resident rooms and facility common areas.

12:10 PM, V2 said she meant to notify the health department about the outbreak yesterday but "never got around to it".

On 11/29/23 at 9:14 AM, V2 said when a COVID outbreak occurs she notifies the health department and staff test every 3-5 days. V2 said she determined the staff would test every Tuesday and Friday. V2 said, "Staff should wear

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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	S9999		

N95 masks, eye protection, gowns and gloves when in contact/droplet isolation rooms. Staff shouldn't just wear their eyeglasses. It's important to ensure isolation precautions are followed as infectious agents can get on clothing and transmitted. I would expect housekeeping staff to wear the same PPE as the other staff when in an isolation room. The droplets stay in there on surfaces. Staff should perform hand hygiene after removing gloves. Hand hygiene is important to control the transmission of potentially infectious materials. Picking a bag with laundry up from the floor of an isolation room and dropping it on the floor in the hall could cause cross contamination. Isolation rooms could be cleaned last. The same housekeeping equipment should not be used in other areas of the facility after cleaning a COVID isolation room without disinfecting first. This could prevent cross contamination and control transmission".

R2's face sheet showed a 66-year-old female with diagnosis of chronic obstructive pulmonary disease, Type 2 diabetes, morbid obesity, schizophrenia, major depressive disorder, anxiety disorder, hypertension, and emphysema.

R2's 11/27/23 1:13 PM progress note showed she had congestion, cough and tested positive for COVID-19 that day.

On 11/29/23 at 7:44 AM, there was contact and droplet precaution isolation signage on R8's closed room door which is next to R2's room. This signage was not present on 11/28/23.

At 7:50 AM, V5 RN said R8 had symptoms of COVID and refused testing.

R8's face sheet showed an 88-year-old male with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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 diagnosis of cellulitis, urinary tract infection, open lower leg wound, and unsteadiness on his feet. R8's 11/28/23 4:13 PM progress note showed R8 exhibited signs and symptoms of respiratory illness. This note showed R8 refused COVID testing and was placed on isolation and presumed positive due to symptoms. The facility's 5/19/23 COVID-19 Control Measures showed in the event of a facility outbreak, all healthcare personnel (HCP) must wear an N95 and eye protection when in an area where they may encounter residents, until testing indicates no further cases are present. Doors should remain closed for residents who have a positive COVID test or are suspected of having COVID-19. Written notification will be provided immediately to the local health department upon confirmation of COVID-19 infection of a resident or staff member. The facility's undated Standard Precautions Policy showed the purpose of the policy was to prevent the spread and contamination of pathogenic microorganisms in a manner that voids transfer to residents, personnel, and environment. Wash hands immediately after gloves are removed between resident contacts and when otherwise indicated to avoid transfer of microorganisms to other residents or environments. The facility's undated Face Mask/Face Shield/ Goggles policy showed protective equipment is to be worn according to the Centers for Disease Control Guidelines to prevent contamination. The facility's 5/30/14 Routine and Terminal Cleaning of Isolation Rooms showed to remove	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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		

all non-disposable resident care items by the double bagging method and take to the soiled utility room for cleaning and disinfecting.

The facility's 5/30/14 Double Bagging Technique Policy showed to ensure proper transport of infectious waste from a resident's room to the facility's holding area, place used items from inside the room to an open bag held by a person outside the room. Transport the plastic bag to the soiled utility room.

On 11/28/23 this surveyor requested evidence the local health department was notified of the facility outbreak. The facility's typed response received hours later showed the local health department was notified 11/28/23 at 12:00 PM (hours after evidence requested and days after the initial outbreak).

2. On 11/28/23, there was a bedside table outside V4 Dietary Manager's office door. The table held COVID testing supplies, and slips of paper to record the date, name of person testing, and results. V4 had the employee COVID testing log which showed the dates of November 26, 27, and 28, 2023 across the top. There were no dates next to individual names to indicate when the tests were done. The log had numerous blanks and was not a complete list of all employees. V2 Director of Nursing (DON) was not on the list.

On 11/28/23 at 10:00 AM, V4 said everyone COVID tests themselves, fills out a paper with the date and result then puts it in her mailbox. V4 takes the papers out of her mailbox and writes the results on the log. V4 said she throws out the papers with the date on them and does not transcribe the date each person tests on the log. A calendar is posted telling staff what two days a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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	S9999		

week to test. V4 said an employee tested positive for COVID on 11/26/23. V4 was unable to tell this surveyor why there were no test results for V2, V5, and V9 as they were currently on duty. V4 did not have an answer and told V4 she needed to test.

V11 and V12 were observed on duty later in the day and no COVID testing was documented.

On 11/29/23, at 9:14 AM, V2 DON/IP said a staff person tested positive for COVID on 11/26/23. On 11/26/23, all residents were tested and all staff who were working. The staff that were not here should test 11/28/23 unless they are symptomatic. If symptomatic they would test sooner. V2 said by looking at the COVID testing log she was unable to tell which employee was tested on which date. V2 was unable to tell this surveyor what day each employee (whose results were on the log) tested. V2 said the staff just know when to test. V2 said, "That's just how they've always done it". V2 was unable to tell this surveyor when each employee would be due for day 3 retesting. V2 said she is the IP for the facility and spends on average two hours a week on infection control duties. V2 was unable to explain why her name was not on the employee testing log or other staff, contracted staff, volunteers and providers. V2 was unable to explain why staff who worked 11/26, 11/27, and 11/28 did not have COVID testing documented. V2 said it's important to comply with testing to identify new infections, decrease transmission, decrease the amount of infection and control the outbreak. V2 said, "I don't know how to monitor that (testing of all employees). I need to come up with a solution. It's important that testing is complete and monitored for compliance as staff could be asymptomatic and spreading a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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 communicable illness". V2 said she had no evidence testing of providers, volunteers, hospice staff had been done. V2 said, "I can't rely on the signs at the front door alerting them to test". The facility's 11/7/22 Testing of Staff and Residents Policy showed its purpose was to enhance efforts to keep COVID-19 from entering and spreading through the facility. Facility staff includes employees, consultants, contractors, volunteers and care givers who provide care and services to residents on behalf of the facility. Upon notification of a single new case of facility associated COVID-19 infection in any staff member or resident, all staff and residents should have a total of three viral tests. The first test should be completed not earlier than 24 hours from the time of exposure, if negative repeat testing 48 hours after initial test and if negative after second test, repeat testing in another 48 hours. (This will usually be days 1, 3, and 5 with date of exposure being day 0). If no further cases of COVID-19 are identified, then no further testing is required. If additional healthcare providers and/or residents test positive during the initial outbreak testing, then residents and staff should be retested every 3-7 days until testing identifies no new cases of COVID-19 involving HCP or residents for a period of 14 days since the most positive result. For outbreak testing, the facility must document the date that all staff are tested. Every effort should be made to obtain testing results from vendors or volunteers who may be tested from another source. The facility's 5/19/23 COVID-19 Control Measures Policy showed to maintain employee infection control log. Review daily to identify any patterns or trends.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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 V2 and V9's Social Services Director timesheets showed they worked 11/27 and 11/28/23 and there were no COVID testing results documented. V5 Registered Nurse (RN) and V11's timesheets showed they worked 11/28/23 and there were no COVID test results logged. V12, V13, and V14 Certified Nursing Assistants (CNAs) timesheets showed they worked 11/26, 11/27, and 11/28/23, yet there were no COVID test results documented. There were six employees on the active employee list that were not on the COVID testing log. The active employee list and testing log did not include hospice staff, volunteers, and providers that were observed onsite. 3. On 11/28/23 at 9:18 AM, R1's room was observed to have a sign on the door showing "isolation room". No signs were posted regarding the type of isolation or PPE (personal protective equipment) was required to enter the room. On 11/29/23 at 8:30 AM, V5 RN (Registered Nurse) said R1 was on Covid isolation which includes droplet precautions. The staff should be wearing a gown, gloves, N95 mask and eye protection. V5 said an isolation sign should have been placed on his door indicating droplet precautions. V5 said the V2 (Director of Nursing) had set up the room. On 11/29/23 at 8:35 AM, V2 said R1 is on covid isolation which includes contact and droplet precautions. V2 said he should have signs posted on his door for each of the types of isolation. The signs let staff know what type of PPE to wear into the room.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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 (B) Statement of Licensure Violations (2 of 6): 300.1035a)2) 300.1035d) Section 1035 Life-Sustaining Treatments a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be: 2) the implementation of physician orders limiting resuscitation such as those commonly referred to as "do-not-resuscitate" orders. This policy may only prescribe the format, method of documentation and duration of any physician orders limiting resuscitation. Any orders under this policy shall be honored by the facility. d) Any decision made by a resident, an agent or a surrogate pursuant to subsection (c) of this Section must be recorded in the resident's medical record. Any subsequent changes or modifications must also be recorded in the medical record. This REQUIRMENT was not met as evidenced by: Based on record review and interview, the facility failed ensure a residents advanced directives were ordered by the physician and updated into his medical record for 1 of 5 residents (R1) reviewed for advanced directives in the sample of 8.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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 The findings include: R1's admission record documents he was admitted to the facility on 10/28/23. The same record shows his advance directive is to be a full code. The 11/3/23 care plan for R1 shows he requests to be a full code and will be resuscitated if found unresponsive. The order summary sheet for R1 shows he has a physicians order for full code status. The electronic health record shows code status as full code. R1's medical record was reviewed and shows a POLST (Practitioner Oder for Life-Sustaining Treatment) form indicating a Do not Attempt Resuscitation/ DNR status, signed 6/2/2019. R1's office clinic notes of 11/1/23 show he was seen by the NP (Nurse Practitioner) and his code status was changed from full code to DNR. On 11/29/23 at 9:30 AM, V5 RN (Registered Nurse) said the code status of residents is located on the front of each chart or on the electronic health record. V5 said upon finding a resident unresponsive she would initially look at the electronic record for the code status. V5 said the code information is updated upon admission and by social services or the administration. V5 reviewed R1's record and said she would inmate CPR (Cardiopulmonary Resuscitation) if she found him unresponsive. V5 said it is very important for the code status information to be accurate and up to date. On 11/29/23 at 9:49 AM, V9 (Social Service) said she completes the admission paperwork including the advanced directives. V9 places the information on the chart and nursing inputs the information into the computer. V9 said she	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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 reviewed the code status with R1's wife upon admission and she wished for him to remain a DNR. On 11/29/23 at 9:54 AM, V2 DON (Director of Nursing) said she takes responsibility for the changes. V2 said the electronic medical record should have the most accurate information for the nurses. The facility's 9/27/17 policy for advanced directives sates individual have the right to make their own decision, and to formulate advance directive to serve as decisions when the individual is incapacitated. 4. Any decision made by the resident shall be indicated in the chart in the manner easily understood by the staff. Those residents indicating "do not attempt resuscitation/DNR" shall be corded as a DNR. Staff must be aware of any requests for limited medical interventions shall be recorded appropriately on the care plan. Code status shall also be recorded on the resident's physician order sheet. (C) Statement of Licensure Violations (3 of 6): 300.1640g) Section 300.1640 Labeling and Storage of Medications g) Each single unit or unit dose package shall bear the proprietary or nonproprietary name of the drug, strength of dose and total contents delivered, lot or control number and expiration date, if applicable. This REQUIREMENT was not met as evidenced	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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 by: Based on observation, interview and record review the facility failed to ensure expiration dates were labeled on insulin for 1 of 1 residents (R7) reviewed for medication storage in the sample of 8. The findings include: R7's admission record shows she was admitted to the facility on 9/20/22. The order summary sheet documents physician order for Fiasp (insulin) 100 unit/ml vial and to inject 20 units subcutaneously with meal for DM (Diabetes Mellitus). Levemir subcutaneous solution 100 unit/ml (insulin Detemir) Inject 60 units subcutaneously in the morning related to type 2 diabetes mellitus without complications. On 11/29/23 at 9:00 AM, the medication cart was observed to have Levemir insulin and Fiasp insulin for R7 in 2 separate bags. Both vials were opened, and the labels on each of the bags did not have the date when the vials were opened and no expiration date. On 11/29/23 at 9:00 AM, V5 RN (Registered Nurse) said each of the vials should have dates when they are opened. After the vials have been opened, they are only good for 28-30 days depending on the type of insulin. V5 said the insulin should be discarded if it does not have an expiration date on the label. On 11/29/23 at 11:30 AM, V2 DON (Director of Nursing) said insulins are only good for 30 days after the vial has been opened. The vials should be discarded at the expiration date. The reason for this is once the vial is opened the medications	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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 only lasts for 30 days. If a vial is found undated, it should be discarded and a new vial opened. On 11/29/23 at 1:00 PM, V1 (Administrator) said the facility did not have a specific policy for insulin storage and would follow the pharmacy recommendations for labeling and storage. The insulin storage recommendations provided by the pharmacy shows fiasp and Levemir insulins are good for 28 days once opened. (C) Statement of Licensure Violations (4 of 6): 300.2080a) Section 300.2080 Menus and Food Records a) Menus, including menus for "sack" lunches and between meal or bedtime snacks, shall be planned at least one week in advance. Food sufficient to meet the nutritional needs of all the residents shall be prepared for each meal. When changes in the menu are necessary, substitutions shall provide equal nutritive value and shall be recorded on the original menu, or in a notebook marked "Substitutions", that is kept in the kitchen. If a notebook is used to document substitutions, it shall include the date of the substitution; the meal at which the substitution was made; the menu as originally written; and the menu as actually served. This requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the menu was followed for the lunch meal on 11/28/23. This	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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 applies to all 28 residents in the facility except one resident that is nothing by mouth and received tube feeding. The findings include: The facility's Week 3 Tuesday menu approved by the registered dietician showed the regular diets, mechanical soft diet and pureed diets were to consist of the following: rosemary pork steak, party potatoes, carrots, roll/margarine, and escalloped apples. On 11/28/23 at 10:36 AM, V10 (Cook) pureed the rosemary pork steak and carrots for 6 residents on pureed diets. V10 stated she did not puree any party potatoes for the pureed diets and made instant mashed potatoes instead. On 11/28/23 at 11:00 AM, the whiteboard on the dining room wall showed the following menu for lunch: rosemary port steak, potatoes, carrots, bread/butter, escalloped apricots and choice of beverage. On 11/28/23 at 11:48 AM, the lunch service tray line was observed after the resident room trays were sent out on a cart. Residents were not served bread, pureed bread or butter. Residents with pureed diets were not given the escalloped apricots and were served pudding instead. V10 (Cook) stated she forgot about the bread. V4 stated the 6 residents with pureed diets were receiving pudding instead of the cobbler (escalloped apricots) because there wasn't enough cobbler available to puree. On 11/28/23 at 11:52 AM, V4 (Dietary Manager) stated it was important to follow the menu to meet the nutritional needs of the residents. V4 stated	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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 she did not know why the menu was not followed or why the bread/butter/margarine was not served. The facility's Therapeutic & Mechanically Altered Diets policy (10/2020) showed, It is the policy of the facility that therapeutic and mechanically altered diets are ordered by the physician and planned by the dietician. The Food Service Manager and/or dietician write an extension of regular diets using the same food when possible. The dietician approves, signs and dates all menus. The facility prepares and serves all therapeutic and mechanically altered diets as planned. On 11/29/23 the facility did not have any other policies available for following the approved menu. (C) Statement of Licensure Violations (5 of 6): 300.2100 Section 300.2100 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 750). This requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the water temperature of the three-compartment sink was checked and maintained according to the facility's policy. The facility failed to ensure chemical sanitization of kitchenware was done according to	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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 the sanitizer's guidelines. This applies to all 28 residents in the facility except one resident that is nothing by mouth and received tube feeding. The findings include: On 11/28/23 at 10:10 AM, V4 (Dietary Manager) stated the facility uses quaternary sanitizer in the third compartment of the 3-compartment sink to sanitize whatever cannot go in the dishwasher. V4 stated the sanitizer should be at 200 - 300 ppm. V10 tested the quaternary sanitizer, and it was at 300 ppm. V4 stated she doesn't check the water temperatures for the 3-compartment sink and does not have any logs. On 11/28/23 at 10:36 AM, V10 (Cook) pureed rosemary pork steaks in the food processor. V10 took the container, lid and removable blade from the food processor and stated she needed to wash it to puree more food. V10 washed and rinsed the food processor parts. V10 dipped the food processor parts in the quaternary sanitizer and placed them next to the sink to dry. V10 did not immerse the food processor parts for 1 minute according to the manufacturer's recommendations or at least 30 seconds per the facility's policy. On 11/28/23 at 10:48 AM, V4 (Dietary Manager) stated she did not know what the immersion time was for the chemical sanitization compartment on the 3-compartment sink. V4 stated she thought it might be 15 - 30 seconds. V10 (Cook) stated she did not know what the immersion time was and thought it may be 15 seconds.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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 18 On 11/28/23 at 10:51 AM, V4 stated the manufacturer recommendations for the quaternary sanitizer they use in the 3-compartment sink stated the immersion time was 1 minute. V4 stated she never knew that. On 11/28/23 at 11:07 AM, V4 showed the facility's Ware-washing - 3 Compartment Sink policy (10/17) and stated the wash temperature on the 3-compartment sink should be at 110 degrees Fahrenheit. V4 stated the facility's policy showed the immersion time should be 30 seconds but the manufacturer recommendations for the quaternary sanitizer they use stated the immersion time should be 1 minute. V4 stated the facility's policy was wrong. The facility's Ware-washing - 3 Compartment Sink policy (10/17) showed, It is the policy of the facility that utensils and dishes that cannot be cleaned and sanitized by a mechanical dishwasher will be cleaned and sanitized in a 3 - compartment sink. Wash items in the first sink. Wash all items in a detergent solution at, at least 110 degrees Fahrenheit. For chemical sanitizing - before sanitizing anything, use a test strip to check the sanitizer level in the third sink. Water temperature in the third sink must be at 75 degrees Fahrenheit. For quaternary sanitizers the level should be 200 ppm. Record either the temperatures or sanitizer level on the 3-compartment sink temperature/sanitizer log. Items must be immersed for at least 30 seconds in the third (sanitizing sink). Check the temperature and concentration of the sinks at regular intervals and change as necessary. The Food Service Sanitation" (77 Ill. Adm. Code 750) showed under section 750.820d)2)4)	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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 19 manual cleaning and sanitizing: d) Except for fixed equipment and utensils too large to be cleaned in sink compartments, manual washing, rinsing and sanitizing shall be conducted in the following sequence: 2) Equipment and utensils shall be thoroughly washed in the first compartment with a hot detergent solution that is kept clean; 4) Equipment and utensils shall be sanitized in the third compartment according to one of the methods in Section 750.820(e)(l) through (4); e) The food contact surfaces of all equipment and utensils shall be sanitized by: 1) Immersion for at least one-half (1/2) minute in clean, hot water at a temperature of at least 170 degrees Fahrenheit; or 4) Immersion in a clean solution containing any other chemical sanitizing agent allowed ...that will provide the equivalent bactericidal effect of a solution at least 50 ppm of available chlorine as a hypochlorite and have a temperature of at least 75 degrees for one minute. (C) Statement of Licensure Violations (6 of 6): 300.2930 d)1)A)B) Section 300.2930 Plumbing Systems d) Hot Water Heater and Tanks 1) Capacity and Temperature Requirements A) The hot water equipment shall have sufficient capacity to supply water at the temperature and quantities in the following areas: Temperature (degrees Fahrenheit) Laundry 180. B) Water temperatures to be taken at the point of use or discharge of the hot water or inlet to processing equipment.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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 20 This REQUIREMENT was not met as evidenced by: Based on observation, interview and record review the facility failed to monitor water temperatures for laundry and linens to ensure the temperature reached 180 degrees Fahrenheit for all 28 residents residing in the facility. The findings include: The entrance census of 11/18/23 documents 28 residents were residing in the facility. On 11/29/23 at 8:40 AM, the laundry room was observed to have a chute emptying linens into a large bin. The room had 2 washers with no readout of what the washing temperatures were for either washer. Chemicals were observed to be on the wall and linked to the washers. On 11/29/23 at 8:46 AM, V15 (laundry aide) said all the laundry is sent down a chute into the basement, including isolation linens. V15 said there was no separate bin or laundry service for isolation linens, and isolation linens were mixed into the rest of the laundry. V15 said the facility had 2 washers and 2 dryers. V15 said all the linens are washed in hot water, but did not know what temperature the water was, and had no way to know how hot the water reached during the washing cycle. On 11/29/23 at 10:30 AM, V8 (maintenance) said he was not able to check the temperature of the washer, the closest he could get was to check to water temperature of the sink. On 11/29/23 at 10:25 AM, V4 laundry supervisor said she was not sure what the water	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007546	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

(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 21 temperature was and did not know what the temperature should reach. V4 said the washers take 3 chemicals: solid detergent, solid sour-soft and solid chlorine sanitizer, but could not say what microorganisms the chemicals would kill. V4 said she would have to contact the chemical company. After contacting the chemical company, V4 said she was advised the chemicals the facility was using did not kill or cover the COVID virus. V4 said there was no logs to show the chemical levels in the washers or the hot water temperatures. The facility provided list of isolation residents shows R1, R2 and R8 are on isolation precautions for Covid-19. The residents are on contact and droplet precautions. The facility's 3/2003 policy for laundry/linen handling shows the purpose of the policy to limit the transmission of pathogenic microorganisms in contaminated linen. Procedures: 6. Laundry facilities should use water temperatures of at least 160 degrees Fahrenheit and 50-150 ppm (parts per million) of chlorine bleach to remove significant quantities of microorganisms from grossly contaminated linen. (C)	S9999		