STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5106197	A. BUILDING: _____ B. WING _____	C 09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD PLACE	1879 CHESTNUT AVE GLENVIEW, IL 60025

(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
A 000	Initial Comment Complaint Investigation 2597147/IL196764 295404a)c) Facility Reported Incident IL196743 295.4040a)c)	A 000		
A4040	Section 295.4040 Communicable Disease Policies This Regulation is not met as evidenced by: Type 2 Violation Section 295.4040 Communicable Disease Policies a) The establishment shall meet the Control of Communicable Diseases Code (77 Ill. Adm. Code 690). b) The establishment shall not knowingly admit a person with a communicable, contagious, or infectious disease, as defined in the Control of Communicable Diseases Code. A resident who is suspected of or diagnosed as having any such disease shall be placed in isolation, if required, in accordance with the Control of Communicable Diseases Code. If the establishment believes that it cannot provide the necessary infection control measures, it shall initiate residency termination pursuant to Section 80 of the Act. c) All illnesses required to be reported under the Control of Communicable Diseases Code and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693) shall be reported immediately to the local health department and to the Department. The establishment shall furnish	A4040		

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A4040	Continued From page 1 all pertinent information relating to such occurrences. In addition, the establishment shall also inform the Department of all incidents of scabies and other skin infestations. These Requirements Were Not Met As Evidenced By: Based on interview and record review the facility failed to follow the COVID-19 guidelines for testing residents and reporting to the local health department for preventing the spread of COVID-19 . This involvest 16 of 16 residents reviewed (R1-R16). This failure has the substantial probability of harm to all residents in the facility. The findings include: The facility's census list provided 9/19/25 shows 37 residents residing in the facility. On 9/19/25 at 8:55 AM, E1 (Staff Developmental Director) said the facility had a COVID outbreak last month, "mainly me" and E10 (Former Clinical Staff Director) were managing the COVID outbreak. On 9/19/25 at 9:46 AM, E5 (Licensed Practical Nurse) said the facility had a COVID outbreak last month. R14 tested positive for COVID-19 on 8/5/25. Residents who tested positive for COVID-19 were on the first and second floor. Residents should be tested twice a week during an outbreak. If there are no new covid positive COVID-19 cases after 14 days they are out of outbreak status. Nursing was testing residents and documenting in the resident's medical records.	A4040		

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A4040	Continued From page 2 The facility's undated COVID-19 line list shows provided on 9/19/25 shows thirteen residents (R1-R13) tested positive for COVID-19. R1-R11 tested positive on 8/2/25 and R12-R13 tested positive on 8/4/25. On 9/19/25 at 12:25 PM, E2 (Clinical Service Director) said she works for another building and was not at the facility during the outbreak. When a resident tests positive for COVID-19 they should be placed in isolation for 10 days, COVID-19 monitoring, staff should wear PPE including mask, gown and gloves. Residents and staff tested twice a week. Nursing should document in the progress notes the results of the COVID test. E2 was informed R14 was not on the COVID-19 line list and said she would provide an up to date list. On 9/19/25 at 12:45 PM, E1 said COVID outbreak should be reported to the local health department and she is not sure if E5 submitted the updated list. On 9/19/25 at 2:06 PM, E2 confirmed there were no COVID testing for residents after the last positive cases on 8/5/25 and residents should have been tested twice a week. The facility's updated line list provided on 9/19/25 shows R14-R16 tested positive for COVID-19 on 8/5/25. The facility did not provide documentation resident testing was done after 8/5/25. E5's email dated 8/3/25 shows eleven residents and one staff were reported to the local health department and there was no reporting of R12-R16 testing positive for COVID-19. The facility's COVID-19 Policy revised 10/23	A4040		

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A4040	Continued From page 3 states, "The establishment will follow these updated procedures and guidelines for managing and preventing the spread of COVID-19...COVID-19 recommendations from both CDC and local health department can change based on new viral variants...will community will maintain regular contact with local health department personnel to ensure the community is compliant with all local health department regulations.." Create a Process to Respond to SARS-CoV-2 Exposures Among HCP and Others Healthcare facilities should have a plan for how SARS-CoV-2 exposures in a healthcare facility will be investigated and managed and how contact tracing will be performed. The Centers for Disease Control and Prevention (CDC) website: Infection Control Guidance: SARS-CoV-2 updated May 2023 states, 1. Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic If healthcare-associated transmission is suspected or identified, facilities might consider expanded testing of HCP and patients as determined by the distribution and number of cases throughout the facility and ability to identify close contacts. For example, in an outpatient dialysis facility with an open treatment area, testing should ideally include all patients and HCP. Depending on testing resources available or the likelihood of healthcare-associated transmission, facilities may elect to initially expand testing only to HCP and patients on the affected units or departments, or a particular treatment schedule or shift, as opposed to the entire facility. If an expanded testing approach is	A4040		

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A4040	Continued From page 4 taken and testing identifies additional infections, testing should be expanded more broadly. If possible, testing should be repeated every 3-7 days until no new cases are identified for at least 14 days.	A4040		