STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145271	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Litchfield Health & Rehab Center	628 S Illinois Ave Litchfield, IL 62056

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on observation, interview, and record review, the facility failed to provide privacy during wound care for 1 of 15 residents (R12) reviewed for privacy in a sample of 46. Findings include: R12's Face Sheet documented he was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction, polyneuropathy and hypertensive heart and chronic kidney disease with heart failure. R12's Minimum Data Set (MDS) dated [DATE], documents R12 as moderately cognitively impaired. R12's Care Plan dated 3/4/25, documents R12 has a pressure ulcer to rear right flank and requires assist with turning and repositioning. On 3/19/25 at 10:20 AM, R12 was provided wound care by V21, Assistant Director of Nursing/Infection Preventionist, with V22, Registered Nurse (RN), V19 RN, and V31 Minimum Data Set (MDS) Coordinator all present. R12's pants and brief were pulled down while he was rolled on his right side to expose his wound while V21 provided wound care while his curtain and window shade were wide open. At 10:35 AM, V21 stated, I can't believe I forgot to close the curtain. On 3/20/25 at 12:05 PM, V17, Certified Nurse's Aide (CNA) stated during resident care she closes the curtains and window shades to provide the resident privacy. On 3/20/25 at 12:06 PM, V32 Licensed Practical Nurse (LPN) stated she absolutely closes the curtains and window shades during resident care to provide privacy. On 3/20/25 at 12:07 PM, V33, CNA stated she closes the closes the curtains and window shades during resident care to provide privacy. On 3/19/25 at 4:05 PM, V1, Administrator, stated she expects staff to close room curtains and window shades while the resident's body is exposed during care. The facility's Contract Between Resident and Facility; Attachment E: Statement of Resident Rights, undated, documented the resident has, the right to respect for bodily privacy and dignity at all times, especially during care and treatment.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108 Based on observation, interview, and record review the facility failed to perform proper and safe transfers for 4 of 5 residents (R1, R31, R36, R46) reviewed for supervision to prevent accidents in the sample of 46. Findings include: 1. R46's Care Plan, dated 4/30/2024, documents that (R46) has a self-Care Deficit As Evidenced by: Needs assistance with ADLs (activity of daily living) and Transfer: One-person physical assistance required with wheeled walker. R46's Minimum Data Set (MDS), dated [DATE], documents that R46 is moderately cognitively impaired and requires supervision/touching assistance with transfers. On 3/17/2024 at 10:24 AM, V18, Certified Nurse's Aide, CNA, transfer R46. R46 was sitting on toilet andV18 was standing bathroom door. R46 then stood up from toilet. V18 grabbed a hold of R46's arm and guided R46 to the wheelchair. V18 encouraged R46 to wash her hands. R46 agreed and rolled towards the sink. V18 grabbed R46 under her left arm assisted R46 into a standing position from the unlocked wheelchair. V18 holding onto R46s arm assisted R46 into her unlocked wheelchair allowing the wheelchair to roll back away from the sink. On 3/20/2025 at 11:29 AM V18 stated R46 had taken herself to the restroom. V18 stated that she responded to R46 transferring and did not have the gait belt. V18 stated that she should have applied the gait belt when transferring R46. V18 stated that she left the gait belt on a different resident. On 3/20/2025 at 11:17 AM V5, CNA, stated that if she responds to a resident that requires assist with transfers, she uses a gait belt. When asked if she does not have one, V5 stated V5 pulls call light in bathroom and she calls for one On 3/20/2025 at 11:21 AM V34, CNA, stated when transferring a resident that requires assist a gait belt is used. V34 stated that if they enter a room and the resident has transferred themselves and she doesn't have one (gait belt) she calls to get one. 50628 2. R1's undated face sheet documented that she was admitted to the facility on [DATE] with diagnoses of dementia, chronic obstructive pulmonary disease, chronic kidney disease, and hypertension. R1's MDS dated [DATE] documented she has severe cognitive impairment. She has no upper or lower extremity impairment but requires the use of a wheelchair for mobility. She is always incontinent of stool and frequently incontinent of bladder. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's Care Plan dated 2/12/25 documented she has a low air mattress on bed with 1/4 rails for safety with mattress and is at risk for falls and injuries with a goal to decrease fall risk. The interventions include assessing toileting needs, bed in lowest position always, full mechanical lift for all transfers, mat at bedside when in bed and pressure alarm under the mattress. On 03/18/25 at 2:09 PM R1 transferred to R1's bed from the reclining high back wheelchair via mechanical lift by V23, certified nursing assistant (CNA) and V9 CNA. V23 and V9 did not check the straps of the mechanical lift sling when attached to the sling to check the stability of attachments. No gentle support was provided during transfer. 40650 3. R36's Physicians orders, dated 3/20/2025, documented diagnoses of Rheumatoid Arthritis with Rheumatoid factor of right hand without organ or systems involvement, Alzheimer's disease, unspecified, and age-related osteoporosis without current pathological fracture. R36's Care Plan, dated 12/2/2024, documented, Transfer: Full mechanical lift for all transfers. R36's MDS, dated [DATE], documented, that her cognition was severely impaired and that she was dependent upon staff for chair/bed to chair transfers. On 3/17/2025 at 12:15 PM, R36 was lying in bed and there was a full mechanical lift pad underneath R36 prior to being transferred. V6, CNA, hooked up the pad to the lift. V5, CNA, operated the mechanical lift, V5 lifted R36 up, over her bed, but V6 did not check the lift pad straps prior to V5 moving R36 from bed to wheelchair. 4. On 03/18/25 at 04:00 PM, R31 was lying in bed. The full mechanical lift pad was underneath R31, and it was hooked up to the full mechanical lift, V7, Licensed Practical Nurse and V11, CNA entered the room. No staff member checked to see if the full mechanical lift pad straps were secured to the full mechanical lift prior to moving resident away from the bed, V11 operated the full mechanical lift, and V7 held the wheelchair. No one was supporting and guiding the resident during the transfer, and R31 was swaying back and forth during the full mechanical lift transfer. Care Plan dated 3/10/2025 documented, Transfer: Full mechanical lift with assist x 2 for transfers. MDS dated [DATE] documented, that his cognition was moderately impaired, frequently incontinent of bowel and bladder. and required substantial to maximum assist for chair/bed to chair transfers. It also documented that he uses a wheelchair. R31's Physicians order sheet, dated 3/20/2025, documented diagnoses of Unspecified Sequelae of Cerebral Infarction and Dementia in other disease classified elsewhere unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. On 03/19/2025 at 01:05 PM, V6, Certified Nurse Assistant (CNA), stated that she checks the straps of the full mechanical lift pad before moving the resident away from the bed or the chair. She also stated that 1 person drives the full mechanical lift and the other person guides and supports the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/19/2025 at 01:10 PM, V13, CNA, stated that she checks the straps of the full mechanical lift pad before moving the resident away from the bed or the chair. She also stated that 1 person drives the full mechanical lift and the other person guides and supports the resident. On 03/19/2025 at 01:10 PM, V14, CNA, stated that she checks the straps of the full mechanical lift pad before moving the resident away from the bed or the chair. She also stated that 1 person drives the full mechanical lift and the other person guides and supports the resident. On 03/19/2025 at 01:15 PM, V9, CNA, stated that she checks the straps of the full mechanical lift pad before moving the resident away from the bed or the chair. She also stated that 1 person drives the full mechanical lift and the other person guides and supports the resident. On 03/19/2025 at 02:05 PM, V19, Registered Nurse, stated that 1 person operates the full mechanical lift and the other person guides and supports the resident. On 03/19/2025 at 02:09 PM, V8, Licensed Practical Nurse, stated that 1 person operates the full mechanical lift and the other person guides and supports the resident. The facility's policy, Using a Mechanical Level II, dated 11/01/2023, documented, 1. At least two (2) nursing assistants are needed to safely move a resident with a full mechanical lift. It continues, E. Check the stability of the straps. It continues, 13. Lift the resident 2 inches from the surface to check the stability of the attachments, the fit of the sling and the weight distribution. It continues, 16. Gently support the resident as he or she is moved, but do not support any weight. The facility's policy, Transfer Policy, dated 7/01/2023, documented, 5. When using a gait belt, apply the belt around the resident's waist over clothing. Never apply gait belt over bare skin.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on observation, interview, and record review the facility failed to perform complete incontinence care with an authorized cleansing agent for 4 of 6 residents, (R58, R27, R49, R12) reviewed for Bowel/Bladder Incontinence/ Catheter Care in a sample of 46. Findings include: 1.R58's face sheet documented she was admitted to the facility on [DATE] with diagnosis of, in part, facture of the sacrum, acute respiratory failure with hypoxia and moderate protein-calorie malnutrition. R58's Minimum Data Set (MDS) dated [DATE], documented she was severely cognitively impaired and dependent on the assistance for toileting hygiene. R58's Care Plan dated 2/17/25, documented she required assistance with ADLs (activities of daily living) with interventions of, in part, for staff to provide personal hygiene (one-person physical assist required). On 3/18/25 at 12:35 PM, R58 stated she needed to be cleaned up as she pointed to her groin region. At 12:44 PM V9, certified nursing assistant (CNA) and V10 CNA provided incontinent care to R58. V10 took a wet washcloth with a cleansing agent on it then wiped R58's left groin, took the same section with the same cloth and wiped her right groin, then proceeded to use the same washcloth and section to wipe her midline vaginal area. V9 then handed V10 a new wet washcloth with just water and V10 used it to rinse R58's groin regions and midline vaginal crease and did not dry off the area. V10 then washed R58's buttock region while she was rolled onto her left side and rinsed it without drying it off. 2.R12's face sheet documented he was admitted to the facility on [DATE] with diagnosis of, in part, hemiplegia and hemiparesis following cerebral infarction, polyneuropathy and hypertensive heart and chronic kidney disease with heart failure. R12's MDS dated [DATE], documented he was moderately cognitively impaired and is dependent on assistance with toileting hygiene. R12's Care Plan dated 3/4/25, documented he has a self-care deficit as evidenced by needing assistance with ADLs such as personal hygiene (one-person physical assist required) and he is at high risk for urinary tract infection due to indwelling catheter care and on enhanced barrier precautions as long as catheter is in place. On 3/19/25 at 10:35 AM, V21, Assistant Director/infection preventionist (ADON/IP), provided peri and indwelling catheter care to R12 with the assistance of V10 CNA, while V22, Registered Nurse (RN), V19 RN, and V31 MDS coordinator provided help as needed. V21 used washcloths in warm water with antibacterial hand soap pumped directly from the bottle onto the cloth by V10 for R12's peri and indwelling catheter care. V21 stated we typically use this hand soap for peri-care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The bottle of hand soap used for R12's incontinence care had warnings on the label stating, for external use only: hands only with directions stating, wet hands, apply palmful to hands, scrub thoroughly, rinse thoroughly. On 3/20/25 at 11:24 AM, V17, CNA stated she uses the total body skin and hair cleanser with vitamin E moisturizing lotion while performing incontinence care and has never used anything else. On 3/20/25 at 11:32 AM, V18, CNA stated she uses the total body skin and hair cleanser with vitamin E moisturizing lotion while performing incontinence care. On 3/20/25 at 11:50 AM, V5, CNA stated she uses the total body skin and hair cleanser with vitamin E moisturizing lotion while performing incontinence care. On 3/19/25 at 4:05 PM, V1, Administrator, stated she approved the hand soap to be used for incontinence care despite the bottle warning stating for hands only. V1 stated she expects staff to be folding the washcloths using a different section of it for each wipe and to be drying of the skin after rinsing during incontinence care. 42108 3. R27's Care Plan, dated 3/25/2024, documents that R27 has a self-Care Deficit As Evidenced by: Needs assistance with ADLs (Activity of Daily Living). It also documents Toileting needs - One-to-two-person physical assist required. R27's MDS, dated [DATE], documents that R27 is cognitively impaired and dependent on staff for toileting. On 3/18/2025 at 9:40 AM R27 was sitting in shower chair with gown on. There was wheelchair with a clean incontinent brief observed open on wheelchair. R27 was transferred into wheelchair on, top of the incontinent brief, using mechanical lift. R27 was then transported to her room and transferred into bed using mechanical lift. Upon lifting R27 into bed observed a moderate amount of black stool was observed on the incontinent brief. R27 was then laid on her right side revealing a moderate amount of black stool to buttocks. V12, CNA, using the wet wipes cleansed, V12 wiped R27's left buttock and partial right buttock. V12 then applied the incontinent brief. V12 did not cleanse the peri area, groin, labia, and entire right buttock. 4. R49's Care Plan, dated 12/20/2024, documents that (R49) has a self-care deficit as evidenced by need for assistance with ADL's. It continues Toilet Use - One-person physical assist required. R49's MDS, dated [DATE], documents that R49 is cognitively intact and dependent on staff for toileting. On 3/18/2025 at 10:10 AM V12, CNA, provide incontinent care to R49. R49 was incontinent of urine. R49 stated that she was wet and had urinated on the sheet in the wheelchair. V12 removed the urine-soaked sheet and placed in container. V12 was transferred to the bed using a mechanical lift. Upon rising from wheelchair resident stated that she was urinating at that time. Once in bed V12, using a wet washcloth cleansed both side of the groin. V12 then applied the clean incontinent brief. V12 did not cleanse the inner thighs or buttocks. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/20/205 at 11:13 AM V20, CNA, stated that when cleansing an incontinent resident, they clean the resident's peri area and buttocks. V20 stated that when incontinent both areas area cleansed. On 3/20/2025 at 11:29 AM V18, CNA, stated that she when cleansing a resident that is incontinent of urine, she cleanses both the front and back of the resident because of gravity and the urine goes backwards. V18 stated that she cleanses both the buttocks and the front when the resident is incontinent of stool. Cleanses the legs as well. On 3/20/2025 at 11:17 AM V5, CNA, stated that she cleanses the peri area, inner thighs and buttocks when performing peri care for a resident incontinent of bowel and bladder. On 3/20/2025 at 11:21 AM V34, CNA, stated that when performing incontinent care for a resident incontinent of bowel or bladder the front peri area and back buttocks are cleansed. The facility's Peri Care policy, not dated, documents that Purpose The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. Equipment and Supplies: 4. Cleanser (or other authorized cleansing agent) Steps in the Procedure Place the equipment on the bedside stand. Arrange the supplies so they can be easily reached. Perform hand hygiene. Fill the wash basin one-half (1/2) full of warm water. Place the wash basin on the bedside stand within easy reach. Fold the bedspread or blanket toward the foot the bed. Fold the sheet down to the lower part of the body. Cover the upper torso with a sheet. Raise the gown or lower the pajamas. Avoid unnecessary exposure of the resident's body. Put on gloves. Ask the resident to bend his or her knees and put his or her feet flat on the mattress. Assist as necessary. For a female resident: Wet washcloth and apply soap or skin cleansing agent. Wash perineal area, wiping from front to back. Separate labia and wash area downward from front to back. (Note: if the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches. Gently rinse and dry the area.) Continue to wash the perineum moving from inside outward to the thighs. Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth. If the resident has an indwelling catheter, hold the tubing to one side and support the tubing against the leg to avoid traction or unnecessary movement of the catheter. Gently dry perineum. Ask the resident to turn on her side with her top leg slightly bent, if able. Rinse wash cloth and apply soap or skin cleansing agent. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Rinse and dry thoroughly.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40650 Based on observation, interview and record review, the facility failed to check placement of a gastrostomy tube prior to administering water flushes for 1 of 2 (R42) residents reviewed for enteral feeding tubes in a sample of 46. Findings include: R42's Physicians Orders, dated3/20/2025, documented diagnosis of Hemiplegia and Hemiparesis following unspecified Cerebrovascular disease affecting left dominant side and Dysphagia, Unspecified. On 03/17/2025 at 10:37 AM, A tube feeding was hanging, dated 3/17/25 but not infusing. It was not opened or spiked. R42's Physicians Order Sheet, dated 3/20/2025, documented, Enteral Feed every 6 hours Flush with 125 (milliliters). It continues, Enteral Feed every shift Enteral - Check Residuals before beginning OF feeding and before medication administration. If Greater than 100 cc, HOLD Feedings and Recheck in 1 HR. If not resolved, call (Medical Doctor). R42's Care Plan, dated 7/3/2024, documented, Check for tube placement and gastric contents/residual volume per facility protocol and record. The resident is dependent with tube feeding and water flushes. See MD orders for current feeding orders. On 03/18/2025 at 10:45 AM, V8, Licensed Practical Nurse, performed hand hygiene and donned gloves, obtained tap water in a graduated cylinder, opened a new syringe, filled it with 60ml of tap water, opened R42's gastrostomy feeding tube and pushed flushed R42 enteral feeding tube. She then filled the syringe with another 60ml and pushed flushed into R42's gastrostomy tube and then filled it with another 5 ml of tap water and pushed it into R42 gastrostomy tube. V8 did not check residual or placement of the gastrostomy tube prior to water flushes. R42's Minimum Data Set, dated dated [DATE], documented that her cognition was moderately impaired and that she had a feeding tube. On 03/19/2025 at 02:05 PM, V19, Registered Nurse, stated that she wouldn't check placement every time, but she would auscultate for placement of the feeding tube. V19 also stated that she was a new employee so it would depend upon the facilities policy. On 03/19/2025 at 02:09 PM, V8, Licensed Practical Nurse, stated that yes, she should have checked for placement before flushing R42. Facility's Policy, Enteral Tube Flushing, undated, documented, 5. Pause active feeding if applicable, clamp enteral tube. Remove the plug and cover end of tubing. 6. Verify placement of tube. 7. If anything suggests improper tube positioning, do not administer water flush, feeding or medication. Notify the physician. 8. When correct tube placement has been verified, flush tubing with at least 30ml water (or prescribed amount).

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 50628 Based on record review and interview, the facility failed to ensure a Registered Nurse (RN) was scheduled in the facility for at least 8 consecutive hours a day, 7 days a week. This has the potential to affect all 61 residents who reside in the facility. Findings include: On 3/20/25 at 10:40 AM, V21, Assistant Director/Infection Preventionist (ADON/IP) stated she was not aware of any registered nurse (RN) staffing issues. She stated that we have RNs who works days and RNs who work nights, so she is not aware that has ever happened. On 3/20/25 at 10:45 AM, V5, Certified Nursing Assistant (CNA) stated that she is not aware that an RN has ever not been present for an eight-hour period out of twenty-four hours. On 3/20/25 at 10:50 AM, V2, Director of Nursing (DON) stated that if she was aware that an RN was not available for an eight-hour period she would call an RN in. V2 added that she is on call 24/7 and would come in or V21 would come in. If a resident needed care that only an RN could provide and one was not available, she herself would come in. On 3/17/25 at 9:04 AM, V1, Administrator, provided copies of nursing staff schedules for dates January 1 to March 19, 2025. On 1/12/25, 1/25/25, 1/26/25, 2/8/25, 2/9/25, 2/17/25, 2/18/25, 2/21/25, 2/26/25, 3/4/25, 3/7/25, 3/8/25, 3/11/25, 3/17/25 and 3/18/25 there was no RN coverage for 8 consecutive hours in a 24-hour period. On 3/20/25 at 10:55 AM, V1 stated they have no specific RN policy. V1 stated they follow the guidelines and refer to the staffing policy. The facility's Long-term Care facility Application for Medicare and Medicaid, dated 3/17/25, documents there are 61 residents residing in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108 Based on observation, interview, and record review, the facility failed perform proper hand hygiene and glove changes when performing incontinence care and providing meal service. The facility also failed to don personal protective equipment appropriately when providing care for a resident on enhanced barrier precautions for 5 of 7 residents (R12, R15, R17, R27, R49) reviewed for infection control in a sample of 46. Findings include: 1. R27's Admission Record, not dated, documents that following diagnoses: Frontal Lobe and Executive Function Deficit Following Cerebral Infarction, Heart Failure, Unspecified, Cardiovascular and Coagulations, Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety, Overactive Bladder. R27's Care Plan, dated 3/25/2024, documents that (R27) has a self-Care Deficit As Evidenced by: Needs assistance with ADLs (Activity of Daily Living). It also documents Toileting needs - One-to-two-person physical assist required. R27's Minimum Data Set (MDS), dated [DATE], documents that R27 is cognitively impaired and dependent on staff for toileting. On 3/18/2025 at 9:40 AM V12, Certified Nursing Aide, CNA, perform incontinence care for R27. R27 was incontinent of stool. V12 performed hand hygiene and applied gloves. R27 was transferred to the bed. When lifting R27 from the wheelchair revealed a stool soiled incontinent brief. V12 then removed the incontinent brief, rolled it, and discarded it. V12 then assisted R27 with rolling on side revealing a moderate amount of dark stool on R27's rectum. V12 then cleaned R27's buttocks. With the same soiled gloves V12 then open closet door and obtained incontinent brief. With the same soiled gloves V12 then applied incontinent brief and manipulated R27's covers. 2. R49's Care Plan, dated 12/20/2024, documents that (R49) has a self-care deficit as evidenced by need for assistance with ADL's. It continues Toilet Use - One-person physical assist required. R49's MDS, dated [DATE], documents that R49 is cognitively intact and dependent on staff for toileting. On 3/18/2025 at 10:10 AM observed V12, CNA, perform incontinent care. R49 was incontinent of urine. V12 performed hand hygiene and applied gloves. R49 stated that she was wet and had urinated on the sheet in the wheelchair. V12 removed the urine-soaked sheet and placed in container. V12 then using the same soiled gloves assisted R49 into the bed, touching the lift, sling, and bed. Upon rising from the wheelchair resident stated that she was urinating at that time and V12 removed the urine soiled incontinent brief and placed in the trash. V12 then obtained a new brief from the closet. V12, using a wet washcloth cleansed both side of the groin. Using the same urine soiled gloves, V12 then applied the clean incontinent brief and touching the clean linen and R49 clothing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145271	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Litchfield Health & Rehab Center	628 S Illinois Ave Litchfield, IL 62056

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/20/2025 at 11:13 AM V20, CNA, stated when entering a room with a resident on enhanced barrier the Personal Protective Equipment (PPE) is applied. The gown is applied, and the straps are secured. When asked how she makes sure the gown does not fall during care. V20 stated that she ties the straps. V20 stated that hand hygiene and glove change are performed during care. V20 stated that the gloves are removed, hand hygiene performed and then items in room can be touched. On 3/20/2025 at 11:29 AM V18, CNA, stated that when entering a room with enhanced barrier she applies PPE. The gown is applied and secured. V18 stated that she ties the strap in the back of the gown to assure that the gown stays secure. On 3/20/2025 at 11:17 AM V5, CNA, stated that hand hygiene is performed and residents clothing, briefs are not to be touched by the soiled gloves. V5 stated that the gloves would be removed, wash hands then touch other items. V5 stated that she applied PPE when entering rooms of enhanced barriers posted. V5 stated that she applies the PPE and ties the ties on the back to assure that the gown remains secure during care. On 3/20/2025 at 11:21 AM V34, CNA, stated that hand hygiene is performed during this process (incontinence care) with glove changes. V34 stated that hands are cleaned before touching items in room. V34 stated that she applies PPE when entering enhanced barrier. V34 stated that the Gown is applied, and the straps are secured. When asked how are they secured? V34 stated that they are tied to make sure the gown doesn't fall. 50908 3.R12's face sheet documented he was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction, polyneuropathy and hypertensive heart and chronic kidney disease with heart failure. R12's MDS dated [DATE], documented he was moderately cognitively impaired and is dependent on assistance with toileting hygiene. R12's Care Plan dated 3/4/25, documented he has a self-care deficit as evidenced by needing assistance with ADLs such as personal hygiene (one-person physical assist required) and he is at high risk for urinary tract infection due to indwelling catheter care and on enhanced barrier precautions as long as catheter is in place. On 3/19/25 at 10:35 AM, V21, Infection Preventionist, closed the window curtain then provided peri and indwelling catheter care to R12 with the assistance of V10, Certified Nursing Assistance (CNA), while V22, Registered Nurse (RN), V19, RN and V31 MDS Coordinator, provided as needed help. R12 is on Enhanced Barrier Precautions requiring staff to don gowns and gloves while providing resident care. V10 did not tie her gown completely and had to readjust her gown after it kept sliding off during care. 40650 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145271	A. Building B. Wing	03/20/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 3/18/2025 at 12:58 PM, V5, CNA, pushed the hall meal cart down to R17's room. V5 took R17's lunch tray into him, she donned gloves without performing hand hygiene, rolled R17's head up and set R17's meal tray up, buttered R17's bread and removed the foil off his baked potato. She then doffed her gloves and performed hand hygiene. V5 the pushed the hall cart across from R15's room. V5 then took R2's, tray to her room and handed it to the staff member in there. V5 then returned to the food cart, and at 1:02 pm took R15's lunch tray into her. V5, donned gloves without performing hand hygiene, rolled R15's head of her bed up, and raised R15's bed to place overbed table in place. She then removed R15's baked potato out of the foil and cut it up and added butter. She then removed R15's bread out of the bag, opened the small container of butter and buttered her bread. She then exited R15's room and used ABHR (alcohol based hand rub) for hand hygiene. On 03/19/2025 at 01:05 PM, V6, Certified Nurse Assistant (CNA), stated that she will wash her hands prior to putting on gloves and after she takes them off. On 03/19/2025 at 01:10 PM, V13, CNA, stated that she washes her hands or uses alcohol-based hand rub, before putting on gloves and after taking them off. On 03/19/2025 at 01:10 PM, V14, CNA stated that she washes her hands or uses alcohol-based hand rub, before putting on gloves and after taking them off. On 03/19/2025 at 01:15 PM, V9, CNA stated that she does wash her hands before putting gloves on and after she takes it off. The Facility's policy, Quick Resource Tool: Serving Specific Glove Usage, dated 09/01/2024, documented, 3. If resident needs assistance with food that would require staff to directly touch food items, gloves need to be worn. It continues, 5. Staff must wash their hands prior to putting gloves on and sanitize hands after removing gloves. The Facility's policy and procedure, Handwashing/Hand Hygiene, undated, documented, This facility considers hand hygiene the primary means to prevent the spread of infections. It continues, 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. It continues, 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non- antimicrobial) and water for the following situations. It continues, B. Before and after direct contact with residents. It continues, D. Before performing any non-surgical invasive procedures. It continues, H. Before moving from a contaminated body site to a clean body site during resident care. It continues, J. After handling used dressings, contaminated equipment. It continues, L. After removing gloves. M. Before and after entering isolation precaution settings; N. Before and after eating or handling food. It continues, P. After personal use of the toilet or conducting your personal hygiene. 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. It continues, Applying and Removing Gloves. 1. Perform hand hygiene before applying non-sterile gloves. 2. When applying, remove one glove from the dispensing box at a time, touching on the top of the cuff.