STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145367	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillespie Health & Rehab Ctr	7588 Staunton Road Gillespie, IL 62033

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44967 Based on observation, interview, and record review, the facility failed to provide timely and complete incontinent care for three of seven residents (R31, R38, R216) reviewed for incontinence care in the sample of 49. The Findings Include: 1. R38's Admission Record, dated 4/16/25, documents R38 was admitted to the facility on [DATE] with diagnoses of Chronic Kidney Disease-stage 3, Hypertension, Descending Thoracic Aorta Aneurysm, Cerebral Infarction without residual deficits. R38's Care Plan, dated 3/20/25, documents R38 has a Self-Care Deficit as Evidenced by: Needs assistance with ADLs (activities of daily living). Interventions: Toilet Use - One-person physical assist required. It continues R38 has a Potential for impaired skin integrity related to: falls, impaired mobility, occasional incontinence. Interventions: Provide peri-care as needed. R38's Minimum Data Set (MDS), dated [DATE], documents R38 has a severe cognitive impairment and requires setup or clean-up assistance for toileting, partial/moderate assistance for bathing. On 4/14/25 at 12:58 PM, R38 was seen ambulating down the hall and was being assisted back to her room by V2, Director of Nursing (DON). R38's back of her pants and between her legs were saturated with urine. R38 was seen going into her room and sitting in her recliner. A few minutes later, V4, Certified Nursing Assistant (CNA), entered and assisted R38 to the toilet. V4 donned gloves, removed R38's pants and incontinence brief, ran the water in sink, wet a washcloth, sprayed with peri-wash, wiped the inside of both thighs and down the legs of R38, then put a clean pair of pants on R38's lower legs. R38 then stood up while V4 used a wet washcloth to wipe R38's buttock and anal area, then put R38's brief and pants back on and assisted her to her wheelchair. There was no wiping of R38's groins, front side pubic area, or complete cleaning of R38's genital area. 2. R216's Admission Record, dated 4/16/25, documents R216 was admitted to the facility on [DATE] with diagnoses of Cerebral Vascular Accident (CVA), Aphasia, Dysphagia, Chronic Kidney Disease-stage 2, Hypertension, Congestive Heart Failure, and Progressive Supranuclear Ophthalmoplegia. (continued on next page)

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R216's Care Plan, dated 2/7/25, documents R216 needs assistance with ADLs related to CVA, weakness. Interventions: Bathing and Personal Hygiene - One-person physical assist required, Transfer: Two-person physical assistance required. It continues R216 has a potential for impaired skin integrity. Interventions: Provide peri-care as needed. R216's MDS, dated [DATE], documents R216 has a severe cognitive impairment and is dependent on staff for toileting. R216's MDS documents is always incontinent of both bowel and bladder. On 4/14/25 at 9:55 AM, V4, CNA, entered to assist R216 to the toilet, used the rails by toilet, and upon R216 lowering to toilet, R216 began urinating all over, into his brief, pants, and down his legs. V4 removed R216's brief and pants. R216 grabbed a small piece of toilet paper and tried to wipe himself and upon pulling his hand out from under him, R216 had a handful of feces that he dropped into the toilet and on the seat. R216 then grabbed the handrail with his soiled hand. V4 left the room to get more washcloths, returned and wet cloths, sprayed with peri-wash, then wiped R216's buttocks and anal area. There was no washing of the front side of R216, including his legs. There was no wiping of the handrail after R216 grabbed it with his soiled hand. On 4/17/25 at 8:55 AM, V2, Director of Nursing, DON, stated I would expect the staff to change their gloves when soiled and when going from dirty to clean areas. I would expect the staff to provide timely and complete incontinent care, including cleaning the front and the back side of a resident when soiled. 33112 3. On 4/14/25 at 11:25 AM, V11 CNA and V12 CNA entered R31's room to provide incontinent care. R31 was rolled over to the left side. V11 cleansed the buttocks and rectal area of stool and dried the buttocks and rectal area. R31 was rolled over onto the right side and V12 cleansed and dried the buttock. R31 was placed on his back and his inner thighs and scrotum was cleansed and dried. R31 has an inverted penis which sits on top of his swollen scrotum. R31 urinated a visible amount urine which pooled on top of his scrotum. Neither V11 or V12, cleansed the scrotum again or provided care to the penile head. An incontinent brief was placed on R31, and care was completed. On 4/15/25 at 1:00 PM, V12 stated I was not the one cleaning him but if I would notice that he had urinated on himself, I would have cleaned it. R31's Face Sheet, print date of 4/15/25, documents R31 was admitted on [DATE] and has diagnoses of atherosclerosis of native arteries of other extremities with ulceration and overactive bladder. R31's MDS, dated [DATE], documents R31 is cognitively intact, dependent on staff for toileting, and is always incontinent of bowel and bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy perineal Care Procedure, undated, documents, For a female resident: a wet washcloth and apply soap or skin cleansing agent. b. Wash perineal area, wiping from front to back. (1) separate labia and wash area outward from front to back. (2) Continue to wash the perineum moving from inside outward to the thighs. Rinse perineum thoroughly in same direction, with fresh water and a clean cloth. It continues, (4) Gently dry the perineum. c. Ask the resident to turn on her side with her top leg slightly bent, if able. d. Rinse wash cloth and apply soap or skin cleansing agent. e. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. f. Rinse and dry thoroughly. For a male resident: a. Wet washcloth and apply soap or skin cleansing agent. b. Wash perineal area starting with the urethra and working outward. c. 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. d. Retract foreskin of the uncircumcised male. e. Wash and rinse the urethral area using a circular motion. f. Continue to wash the perineal area including the penis, scrotum, and inner thighs. g. thoroughly rinse perineal area in same order, using fresh water and clean washcloth. h. 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. i. Gently dry perineum following same sequence. j. Reposition foreskin of uncircumcised male. k. Ask the resident to turn on his side with his upper leg slightly bent, if able. l. Rinse washcloth and apply soap or skin cleansing agent. m. Wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks. n. Dry area thoroughly. 9. Discard disposable items into designated containers. 10. Remove gloves and discard into designated container. 11. Perform hand hygiene.

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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** 33112 Based on interview, observation, and record review, the facility failed to check placement of a J-tube (Jejunostomy) and label enteral feeding for 1 of 1 resident (R50) reviewed for tube feeding in the sample of 49. Findings include: On 4/15/25 at 12:30 PM, V14, Licensed Practical Nurse, entered R50's room. R50 has a J-tube for medications and feedings. V14 stopped R50's tube feeding, disconnected the tube feeding, administered 30 milliliters (ml) of water, the hydroxyzine cocktail, and flushed with another 30 ml of water. V14 stated, I have to go and get another ruler. I dropped the one I had. V14 left the room and returned with another ruler and measured the length of the J-tube. On 4/15/25 at 12:40 PM, R50's hanging disposable tube feeding bag is dated 4/15/25. The bag fails to document what type of feeding or rate of the feeding. On 4/15/25 at 12:40 PM, V14 stated, I should have measured the J-tube before I administered the medications. I recently hung a new disposable tube feeding bag and filled it with Jevity 1.5. On 4/15/25 at 12:41 PM, V2, Director of Nurses, stated that the bag is not labeled with the type of tube feeding. V2 stated, Is it supposed to be labeled with the rate? On 4/17/25 at 8:56 AM, V2 stated R50's J-tube should be measured for placement before it is used. V2 stated R50 is our only tube feeder, and everyone knows that she gets Jevity 1.5. R50's Face Sheet, print date of 4/15/25, documents R50 was admitted on [DATE] and has a diagnosis of Multiple Sclerosis and quadriplegia. R50's Physician Orders, dated 3/24/25, documents, Check placement of J-tube by measuring the tube. 12cm (centimeters) From top of Abdominal disk to end of tube prior to adapters. If more than 12cm do not run feeding send res (resident) to ER (emergency room) to verify placement via Xray. R50's Physician Orders, dated 3/10/24, documents, Enteral Feed every shift Administer Jevity 1.5 VIA an Enteral Pump and Infuse at 80 ml/hr (hour). X 20hrs. R50's Physician Orders, dated 2/20/25, documents, every shift Enteral - Medication Administration Flush: Flush with minimum of 30ml water before giving medications, flush with at least 5 ml between medications, and flush with minimum of 30 ml after all medications given. The policy Enteral Tube Feeding via Continuous Pump Procedure, undated, fails to document the procedure for using and labeling disposable tube feeding bags.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40701 Based on observation, interview and record review, the facility failed to ensure a multi dose vial with a shelf life of 30 days was dated to indicate when it was opened and failed to ensure a bottle of controlled substance medication was labeled the residents name and physician's order. This failure has the potential to affect all 63 residents residing in the Facility. Findings include: 1. On 4/14/2025 at 2:52 PM the medication storage room and mediation cart were inspected with V10, Licensed Practical Nurse (LPN). 1. There was a bottle of Morphine Sulfate (Opioid pain medication/controlled substance) in a locked box. Neither the bottle or the box was labeled with a name or physician's orders. At this, time V10 stated the medication had been opened and there had been medication used from the bottle. V10 stated, I don't know whose (medication bottle) that is. That one doesn't even have a name on the box. During this observation, V2, Director of Nursing (DON) entered the medication storage room. V2 stated, That one (morphine bottle) is (R17's). It needs wasted. She doesn't have an order for it anymore. The (a medication disposal system designed to safely and effectively neutralize and contain unused or expired medications, preventing potential misuse, abuse, and environmental contamination) was on back order. We got one in last Tuesday or Wednesday. On 4/15/2025 at 9: 59 AM, V2, stated the bottle of morphine should have been labeled with the resident's name. R17's Order Audit Report dated 4/16/2025 documents R17's Morphine was discontinued on 2/14/2025. 2. Located in the refrigerator, there was a multi-dose vial of Tuberculin Purified Protein Derivative (Mantoux) Tubersol (aids in the detection of infection with mycobacterium tuberculosis) with no cap intact. At this time, V10 verified the vial had been accessed. The label on the vial documented it was opened on 3/1/2025. V2 stated she would call the pharmacy to inquire what they recommend regarding the timeframe and storage of the vial. On 4/15/25 at 9:49 AM, V2 stated she called pharmacy and was informed the vial should be disposed after 30 days of being opened. The Package Insert document titled Tuberculin Purified Protein Derivative (Mantoux) Tubersol dated 4/15/2025 documents, A vial of Tubersol, which has been entered and in use for 30 days should be discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility's Policy titled, Medication Storage dated 7/1/2023 documents, Purpose: To provide guidance to facility nursing staff on the proper storage of medication. It continues, Drug containers that have missing, incomplete, improper or incorrect labels shall be returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals shall be returned to the dispensing pharmacy or destroyed. The Resident's Census and Conditions of Resident, CMS 671, dated 4/14/2025, documents that the facility has 63 residents living in the facility.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview, observation, and record review, the facility failed to provide substitute food choices for 5 of 24 residents (R16, R28, R30, R49, R63) reviewed for meals. Findings include: 1. On 04/14/25 at 12:25 PM, R63 was served her lunch by V6, Dietary Manager, R63 was served a grilled cheese sandwich. R63 stated she wanted turkey. V6 stated she would get her turkey. V6 returned with the turkey. The turkey was on bread and had gravy on top. R63 stated I just want turkey that I could cut up with my knife and eat with a fork. V6 stated, How about a sandwich. V6 folded the turkey into a sandwich and walked away. On 4/15/25 at 2:35 PM, V1, Administrator, stated R63 should have been given plain turkey. V1 stated, She doesn't eat that much already. R63's Face Sheet, print date of 4/15/25, documents R63 was admitted on [DATE] and has diagnoses of Dementia and severe Protein Calorie Malnutrition. R63's Minimum Data Set, (MDS), dated [DATE], documents R63 is severely cognitively impaired and requires set up clean up assistance. 44967 2. R30's Admission Record, dated 4/16/25, documents R30 was admitted to the facility on [DATE] with diagnoses of Cerebral Vascular Infarction (CVA), Hemiplegia and Hemiparesis, and Nutritional Anemia, Type 2 Diabetes Mellitus (DM), and Chronic Kidney Disease-stage 3. R30's Care Plan, dated 1/29/25, documents R30 is receiving a Consistent Carbohydrate Diet (CCHO) regular diet related to (r/t) diagnosis of Diabetes. He may be at risk for malnutrition related to diagnosis of CVA with hemiplegia. Interventions: Encourage R30 to eat at least 75-100% at all meals daily, monitor weight and intakes and refer to Registered Dietitian (RD) as needed (PRN), monitor, document and report to Medical Doctor (MD) PRN for signs/symptoms of dysphagia: Pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals, provide and serve CCHO regular diet as ordered, offer substitutes for dislikes or food uneaten, provide, serve diet as ordered, monitor intake and record all meals, RD to evaluate and make nutritional recommendations PRN, weigh per schedule at same time of day and record. It continues R30 has a potential for safety concerns and injury from hot liquids. Interventions: Set up for meals, staff supervision or assistance with hot liquids. It continues R30 needs assistance with Activities of Daily Living (ADLs). Interventions: Eating - Setup help only / Cueing required. It continues R30 has a potential for impaired skin integrity. Interventions: Encourage oral (PO) intake, provide diet as ordered. R30's Minimum Data Set (MDS), dated [DATE], documents R30 is cognitively intact and requires supervision or touching assistance for eating. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/14/25 at 12:30 PM, R30 seen in small dining room for lunch with no staff seen in the room to assist R30. R30 only ate a few bites of mashed potatoes, a piece of cake, and milk. R30 left the dining room and went to his room. Upon interviewing R30 about not eating, R30 stated I don't like processed Turkey and couldn't cut it up anyway. When asked about staff offering alternatives, R30 stated They don't ask if we want anything different, we get what they serve. 3. R49's Admission Record, dated 4/16/25, documents R49 was admitted to the facility on , with diagnoses of Type 2 DM, Anxiety Disorder, Depression, Hypothyroidism, Anemia, and Dysthymic Disorder. R49's Care Plan, dated 3/20/25, documents R49 may be at risk for malnutrition r/t having multiple dislikes of food and diagnosis of peptic ulcer. R49 is receiving a mechanically altered regular diet r/t having no natural teeth or dentures. Interventions: Encourage R49 to try a variety of foods at all meals, explain and reinforce to R49 the importance of maintaining a balanced diet, encourage R49 to comply, may have hi-pro ice cream with all meals for supplement, monitor weight and for nutritional needs and refer to RD PRN, monitor, document, and report to MD PRN for s/sx of dysphagia: Pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals, offer substitutes for dislikes or for food uneaten, provide and serve diet as ordered, monitor intake and record all meals, RD to evaluate and make nutritional recommendations PRN, weigh per schedule at same time of day and record. It continues R49 is at risk for an ADL Self Care Performance Deficit r/t Musculoskeletal impairment. Interventions: Restorative Eating: R49 will improve her current level of function and consume at least 50% of each meal to provide her with adequate calories needed to prevent a weight loss through next review date, staff to ensure that R49 is at an assisted eating table, provide diet as ordered by MD, provide set up of my tray, provide V/C (verbal cues) to begin eating/drinking, If she does not like what she is offered, staff to provide her with something else to eat. report any c/o (complaints) to nurse. R49's MDS, dated [DATE], documents R49 is cognitively intact and requires setup or clean up assistance for eating. On 4/14/25 at 12:32 PM, R49 seen in small dining room for lunch with no staff seen around. R49's lunch ticket documented R49 is on a Regular Mechanical Soft diet. R49 had a grilled cheese sandwich, a magic cup, and drinks. R49 only ate the magic cup and her milk. When interviewed, R49 stated I don't like grilled cheese sandwiches and that is what they give me almost every day for lunch. I don't even ask for it, that is what they just give me. When asked about alternatives, R49 stated They never ask us if we want something else, they just bring us a tray and we have to eat what is on the tray. On 4/15/25 at 12:20 PM, R49 seen in small dining room for lunch, no staff in the room. R49 only has a grilled cheese sandwich and a cup of chocolate ice cream on her tray, along with a few cups of drinks. R49 is not touching her grilled cheese and stated, I got it again, and did not ask for it. R49 was seen rolling herself out of the dining room without eating anything on her plate. On 4/15/25 at 12:25 PM, when asked about R49 receiving a cheese sandwich every day, V6, Dietary Manager, stated (R49) does not have any teeth and was put on a mechanical soft diet. (R49) asked for bologna and cheese sandwich which she was getting for a while, then didn't want that anymore, so we have been giving her a grilled cheese sandwich for the past couple of weeks, but I guess she's tired of that now. (R49) is a very picky eater and refuses to eat anything ground up. We can have ST (Speech Therapy) re-evaluate her to see if they can advance her diet. ST left for the day, but I will check with them tomorrow. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/15/25 at 12:30 PM, when questioned by V6 about meals, R49 stated I'm not sure what I want. I don't like ground-up meats. Maybe if I get back to a normal meal, I will like that. On 4/16/25 at 1:15 PM, R49 stated Today for lunch, I got meatballs that were chopped up, small potatoes that were cut up, green beans, and a fudge round which I don't like. I only ate a couple of bites of each because I didn't like them. When asked if there was any staff assisting her or asking her if she wanted something else, R49 stated No, I didn't see anyone, and no one asked me if I wanted anything else. 4. R16's Admission Record, dated 4/16/25, documents R16 was admitted to the facility on [DATE], with diagnosis of CVA, Dysarthria, Dysphagia, Morbid Obesity, Dementia, and Major Depressive Disorder. R16's Care Plan, dated 3/11/25, documents R16 has a self-care deficit as evidenced by needs assistance with ADLs. Interventions: Eating: Setup help only / cuing required. It continues R16 has a potential for impaired skin integrity. Interventions: Provide diet as ordered, refer to RD PRN to evaluate diet/needs. R16's MDS, dated [DATE], documents R16 has a severe cognitive impairment and requires Setup or clean-up assistance for eating. On 4/14/25 at 12:34 PM, R16 seen in small dining room for lunch with no staff seen around. R16's lunch ticket documented R16 is on a Mechanical Soft Diet. R16 had turkey, mashed potatoes, cake, and drinks on her plate. R16 stated I don't like the turkey. No one asked me if I want something different, they never do, so we just have to eat what they give us. R16 only ate her piece of cake and a few bites of her mashed potatoes. 5. R28's Admission Record, dated 4/16/25, documents R28 was admitted to the facility on [DATE], with diagnosis of Parkinson's Disease, Vascular Dementia, and Generalized Anxiety disorder. R28's Care Plan, dated 3/3/25, documents R28 is at risk for nutritional deficits r/t having a low BMI (Body Mass Index) of 18.8. Interventions: Alert dietician if consumption is poor for more than 48 hours, encourage fluids at and between meals daily, encourage R28 to eat at least 75%-10% at all three meals daily, Help R28 to fill out her menu and to choose a balanced diet, as she sometimes only orders one item on the menu, monitor and record food intake at each meal, monitor weight & nutritional status and refer to RD PRN, offer substitutes as requested or indicated or for food not eaten, RD to evaluate and make nutritional recommendations PRN, weigh at same time of day and record, report significant weight loss to MD immediately. It continues R28 has a Self-Care Deficit As Evidenced by: Needs assistance with ADLs. Interventions: Eating - Setup help only / Cueing required. R28's MDS, dated [DATE], documents R28 has a moderate cognitive impairment and requires setup or clean-up assistance for eating. On 4/14/25 at 12:35 PM, R28 seen in small dining room for lunch with no staff seen around. R28's lunch ticket documented R28 is on a Regular Diet. R28 was not eating much of her meal and when interviewed, R28 stated They don't ask us what we want to eat, we just have to eat what they bring us, and I don't like that. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/17/25 at 9:00 AM, V2, Director of Nursing (DON), stated I would expect all staff to be checking with the residents to see if they are eating, and if not, offer them something else to eat. On 4/17/25 at 10:00 AM, V1, Administrator, stated I can't find a policy on offering substitutions for dietary. It is posted all over and I understand the residents may not remember they do have substitutions; the staff definitely know and should be offering the residents something if they don't like what is served. V6, Dietary Manager, provide the Facility's Quick Resource Tool: Food Preference and Portions Policy, dated 9/1/21, documents in part Guidelines: 3. The food Preference Interview will be entered into the medical record. 5. The Registered Dietitian/Nutritionist (RDN) or other clinically qualified nutrition professional will review, and after consultation with the resident, adjust the individual meal plan to ensure adequate fluid volume and appropriate nutritional content for residents that do not consume certain foods or food groups. 6. The Dining Service Director, RDN or other clinically qualified nutrition professional, or designee, will enter information pertinent to the individual meal plan into the plan of care. 7. The individual tray assembly ticket will identify all food items appropriate for the resident/patient based on diet order, allergies, and alternate selection of comparable nutrition value. 9. The alternate meal and/or beverage selection will be provided in a timely manner. The Meal Assistance Policy, dated 7/3/23, documents, Policy: Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. It continues, Facility Staff will serve resident trays and will help residents who require assistance with eating.

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	145367	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillespie Health & Rehab Ctr	7588 Staunton Road Gillespie, IL 62033

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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** 33112 Based on interview, observation, and record review, the facility failed to perform hand hygiene, change gloves when soiled, cleanse soiled surfaces, wear Personal Protective Equipment, and track infections for trends for 5 of 16 residents (R31, R41, R50, R55, R216) reviewed for infection control in the sample of 49. Findings include: 1. On 4/16/25 at 10:57 AM, V3, Infection Preventionist was questioned on how she tracks the infections in the facility. V3 stated she looks at the 24-hour report for new antibiotic orders, checks the order, and puts that information on the tracking sheet that she uses. V3 was questioned why on the monthly infection tracking log R41 is documented as needing contact precautions what type of infection did she have, V3 reviewed the culture and stated, Oh she doesn't does she? I guess it would be standard precautions. V3 was questioned how she tracks for trends in the infections, V3 stated, I keep track of it in my mind. We are a small home. R41's Face Sheet, print date of 4/17/25, documents, R41 was admitted on [DATE]. R41's Health Status Note, dated 4/11/2025, documents, Resident seen by MD (Medical Doctor) Received orders for Levaquin 250 mg (milligram) PO (oral) daily x 7 days for a UTI (urinary tract infection). R41's Urine Culture, dated 4/11/25, documents Organism: serratia marcescens > 100,000 CFU (colony forming unit)/ ml (milliliter). The Infection Prevention and Control Log, dated April 2025, documents, R41 has an in house acquired urinary tract infection with the organism of serratia marcescens which requires contact isolation. This log entry fails to document the onset date, or the colony count of the organism. The Policy Antibiotic Stewardship policy/ Procedure, dated 7/1/23, documents, Data will be compiled by the infection preventionist, who will interpret monthly data, define necessary action steps, and compile information for the Monthly ASP (Antibiotic Stewardship Program) Tracking Report. 2. On 4/15/25 at 12:30 PM, V14, Licensed Practical Nurse, put gloves on without hand hygiene and opened a 25-milligram hydroxyzine capsule and mixed it with 3 milliliters (ml) of water. V14 entered R50's room. R50 has a J-tube for medications and feedings. V14 stopped R50's tube feeding, disconnected the tube feeding, administered 15 ml of water, the hydroxyzine cocktail, and flushed with another 15 ml of water. On 4/16/25 at 11:25 AM, V14 was questioned why she did not perform hand hygiene before putting on gloves, V14 stated, I thought I did. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 4/14/25 at 11:25 AM, V11, Certified Nurse Aide (CNA) and V12 CNA entered R31's room to provide incontinent care. Neither V11 nor V12 wore a Personal Protective gown while providing incontinent care. V11 changed gloves 3 times without hand hygiene in between. V12 changed gloves 2 times without hand hygiene in between. R31's door has signage that R31 is on Enhanced Barrier precautions. On 4/15/25 at 2:35 PM, V2, Director of Nurses, stated R31 is on Enhanced Barrier Precautions and staff should be using gowns and gloves with patient care. On 4/15/25 at 1:00 PM, V12 stated I did not know that he was on Enhanced Barrier Precautions. R31's Face Sheet, print date of 4/15/25, documents R31 was admitted on [DATE] and has diagnoses of atherosclerosis of native arteries of other extremities with ulceration and overactive bladder. The policy perineal Care Procedure, undated, documents, 10. Remove gloves and discard into designated container. 11. Perform hand hygiene. The policy Enhanced Barrier Precautions, undated, documents, The use of gown and gloves for high - contact resident care activities are indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and /or indwelling medical devices regardless of MDRO (multi drug resistant organisms) colonization as well as for residents with MDRO infection or colonization. It continues, Examples of high- contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing. Bathing / Showering. Transferring. Providing hygiene. Changing linens. Changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding, tracheostomy / ventilator. Wound Care 44967 4. R55's Admission Record, dated 4/16/25, documents R55 was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction with Hemiplegia and Hemiparesis, Dysphagia, Emphysema, Asthma, Congestive Heart Failure, Major Depressive Disorder, Generalized Anxiety Disorder, Malignant of Neoplasm of Sigmoid Colon, Gastrointestinal Hemorrhage, and Diverticulitis. On 4/15/25 at 1:05 PM, R55 used call light to let staff know he had to use restroom. V4, CNA, assisted R55 to the toilet to have bowel movement (BM). When finished, V4 wiped R55's buttocks and anal area with a wet washcloth sprayed with peri-wash, then dried R55. Using the same soiled gloves, V4 then pulled R55's incontinence brief and pants up, adjusted R55's shirt, and assisted R55 back to his wheelchair, then removed her soiled gloves. 5. R216's Admission Record, dated 4/16/25, documents R216 was admitted to the facility on [DATE] with diagnoses of Cerebral Vascular Accident (CVA), Aphasia, Dysphagia, Chronic Kidney Disease-stage 2, Hypertension, Congestive Heart Failure, and Progressive Supranuclear Ophthalmoplegia. On 4/14/25 at 9:55 AM, V4, CNA, entered to assist R216 to the toilet, used the rails by toilet, and upon R216 lowering to toilet, he began urinating all over, into his brief, pants, and down his legs. R216 grabbed a small piece of toilet paper and tried to wipe himself and upon pulling his hand out from under him, R216 had a handful of feces that he dropped into the toilet and on the seat. R216 then grabbed the handrail with his soiled hand. After V4 cleaned R216, there was no wiping of the handrail after R216 grabbed it with his soiled hand. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/20/25 at 8:20 AM, V19, CNA, stated I change my gloves any time they are soiled, and when going from a soiled area to clean area. If I am doing incontinent care and wiping the resident from a BM, I change my gloves after wiping the back and before wiping anywhere else or putting their clothes on. I think it's better to change gloves more often than not. On 4/17/25 at 8:55 AM, V2, Director of Nursing, stated I would expect the staff to change their gloves when soiled and when going from dirty to clean areas. Anytime there is a piece of equipment or something like the handrail in a resident's restroom that is soiled, I would expect the staff to clean that before leaving the room. The Facility's Hand Washing Policy, dated 7/1/23, documents To provide guidelines for adequate hand washing in order to reduce the transmission of organisms for resident to resident, staff to resident, and from resident to nursing staff. It is the responsibility of all staff to ensure that they properly wash their hands after direct contact with resident, contaminated substances, and as needed. Procedure: 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 6. If hands are not visibly soiled, use hand sanitizer: f. Before moving from contaminated body site to a clean body site during resident care.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview and record review, the facility failed to justify the use of an antibiotic and utilize infection surveillance when considering initiation of an antibiotic for 2 of 4 (R32, R41) residents reviewed for antibiotic stewardship in the sample of 49. Findings include: 1 On [DATE] at 10:57 AM, V3, Infection Preventionist was questioned on how she tracks the infections in the facility. V3 stated she looks at the 24-hour report for new antibiotic orders, checks the order, and puts that information on the tracking sheet that she uses. V3 stated that the computer program infection tracker has the information on McGreer and the cultures if any were obtained. V3 was asked to pull up R41's McGreer assessment for a urinary tract infection that is on the monthly infection tracking log. V3 pulled up the McGreer and stated, I am not sure how the system works because it never tells you if they qualify for a true infection. V3 was questioned what symptoms R41 presented with to get a urine culture, V3 stated, Her daughter requested it, and it turned out she had an infection. R41's Face Sheet, print date of [DATE], documents, R41 was admitted on [DATE]. R41's Health Status Note, dated [DATE], documents, Resident seen by MD (Medical Doctor) Received orders for Levaquin 250 mg (milligram) PO (oral) daily x 7 days for a UTI (urinary tract infection). R41's Infection Screening Evaluation, dated [DATE], documents a blank Infection Analysis. 40701 2. On [DATE] at 1:50 PM, V5, Licensed Practical Nurse (LPN) stated, (R32) would try to clean herself up (after using the restroom) and didn't do a very good job. She kept getting UTIs (Urinary Tract Infections). We finally talked the doctor into putting her on something prophylactic. On [DATE] at 12:39 PM, V3 (Infection Preventionist) stated, (R32) had a lot of UTIs. We did not get a culture prior to her starting it. She's been on it a while-since March of 24 (2024). We don't always check cultures before starting an antibiotic. Some doctors just start them on something (antibiotic). A lot of times the hospital will start them on something, and I'll have to call. One time (a resident)'s culture wasn't susceptible (to the antibiotic), so I have to get it stopped, but he had already been on it for five days. I am not finding a culture for (R32) (urine). The last one I can find was from March of '23 (2023) and it had no growth. R32's Progress Note dated [DATE] documents a new physician's order was received to discontinue Macrobid for UTI prevention. On [DATE] at 2:00 PM, V15, Nurse Practitioner stated, As primary physicians we don't prescribe prophylactic antibiotics. If the family is requesting it, we would send them to a urologist. We use the McGeer's criteria and most of the time, the resident wouldn't meet it. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:06 PM, V3 stated the doctor who prescribed R32's antibiotic is a nurse practitioner, not a urologist. V3 stated she will call and get the antibiotic discontinued. R31's Medication Administration Record (MAR) documents R32 began Nitrofurantoin 100 mg daily on [DATE] and it was discontinued on [DATE]. On [DATE] at 10:19 AM, V3 stated, I'll be honest. I am the one who requested the prophylactic antibiotic for (R32). She would double over in pain when she went to the bathroom. That was pretty much her only symptom. She has not been seen by a urologist. We are supposed to do an infection screening form with an analysis. V3 verified she did not have an infection screening evaluation for R32 and that R32's last urine urinalysis was done in 2023. The Facility's Antibiotic Stewardship Policy/Procedure dated [DATE] documents, Antibiotics are powerful tools for fighting and preventing infections. However, widespread use of antibiotics has resulted in an alarming increase in antibiotic-resistant infections and a subsequent need to rely on broad-spectrum antibiotics that might be more toxic and expensive. In addition to the development of antibiotic resistance, antibiotic use is associated with an increased risk of Clostridium difficile (a bacteria that can cause a serious infection in the intestines, leading to severe diarrhea and inflammation of the colon, a condition called colitis) infection and adverse drug reactions. Since antibiotics are frequently over or inappropriately prescribed, a concerted effort to decease or eliminate inappropriate use can make a big impact on resident safety and the reduction of adverse events. Antibiotic stewardship consists of coordinated interventions aimed at treating infections while promoting appropriate antibiotic use. The practice of antibiotic stewardship requires commitment, leadership, communication and actions informed by best practice guidelines and defined protocols. It continues to document, Assessment of resident suspected of having an infection. Providers will utilize the McGeer Criteria when considering initiation of antibiotics. Consistent with these criteria, the criteria for urinary tract infection form should be provided to, or information communicated with, the provider. It is encouraged that McGeer criteria be used for other suspected infections. It further documents urinalysis and cultures should be considered.