STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145445	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hill	623 Hamacher Street Waterloo, IL 62298

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on interview and record review the facility failed to identify and immediately report allegations of physical and sexual abuse for 4 (R5, R124, R430, R103) residents reviewed for abuse. This failure has the potential to affect all residents in the facility. Findings include: 1. R5's face sheet, dated 8/14/24, documented R5 has diagnoses of dementia, depression, generalized anxiety disorder, and hypertension. R5's MDS (Minimum Data Set), dated 5/22/24, documented R5 is severely cognitively impaired. R5's incident report, dated 8/9/24 at 5:30 pm, documented R5 has a 2 cm by 2 cm raised dark purple bruise noted to the left side of forehead. On 8/13/24 at 9:05 am R5 was observed with an approximately 2 cm by 2 cm yellow and purple bruise to the left side of her forehead. R5 was unable to recall how she obtained the bruise. V12 CNA (Certified Nurse Assistant) documented in a written statement dated 8/9/24 I was in the resident (R5) room this morning with employee V13 CNA. We were getting the resident up and the resident was acting a little combative, upon putting the resident in the chair with the lift R5 started swinging and V13 grabbed the resident's hand and was really like tussling with the resident and was pretty rough. I was in awe. I had never witnessed anything like that before. In the midst of the tussling the resident was still hooked up to the machine and the iron from the lift hit her forehead. Upon leaving the room I had told my hall partner V14 about it and another CNA and they said that V13 had been reported before about abuse on several occasions and nothing had been done so I was hesitant about saying anything because if V13 has been reported before and nothing been done. I'm thinking what would make anyone think I'm telling the truth. But as I was going to the dining room, I seen R5 in the hallway, she had a green bruise on her forehead, so I knew I had to put my trust in God and report it. These residents are vulnerable, and they don't deserve to be abused. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/13/24 at 12:51 pm V12 stated that on 8/9/24 around 8:30 am she and V13 CNA went to get R5 out of bed. V12 stated that V13 was already frustrated because she said she didn't want to work that hall. V12 stated R5 was a little combative when she was in the lift, R5 was transferred into her chair, the lift was still connected to R5, and that V13 aggressively grabbed R5's arm, and then started to tussle with R5. V12 stated that V13 was swinging her arms and her hand hit R5's arm and that V13 continued to tussle with R5. V12 stated the iron bar hit R5's forehead during the tussle. V12 stated that she went and told the other CNAS and that they stated nothing will be done as V13 has been reported before. V12 stated that she did not report the incident until that evening when she saw the bruise on R5's head. On 8/13/24 at 8:50 am V1 Administrator stated that V12 did not report the allegation against V13 until 5:30 pm on 8/9/24. V1 stated that she suspended V12 for not immediately reporting the incident and she suspended V13 pending investigation. 2. R124's face sheet, dated 8/14/24, documented R124 has diagnoses of dementia, generalized anxiety disorder, hypertension, pulmonary fibrosis, chronic kidney disease, and depression. R124's MDS, dated [DATE], documented R124 is severely cognitively impaired. Statement dated 7/22/24 by V11 RN, ADON (Registered Nurse, Assistant Director of Nursing) documented On Monday, July 22, 2024, I asked V15 RN how R124 was doing. I had heard over the weekend she was having some behavior issues such as hitting, kicking, and refusing medications. V15 stated that this past weekend was terrible, and that R124 would not take medications, was yelling at staff, and then she called her granddaughter on Saturday and told her that the male staff members here rape the residents. I asked V15 who overheard R12 call her granddaughter and V15 stated that she is the one who overheard this conversation. V15 then proceeded to tell me that V16 CNA was taking care of R124 this weekend and she yelled RAPE! very loudly, multiple times while V16 was in the room with her. V15 stated that V16 was scared by this and yelled for a nurse's help. I immediately reported this information to V2 DON. I then called V16 and asked for his side of the story, and his story coincided with V15's story. I explained to him that if anything like this were to happen that he needs to report it to V1 or V2 immediately. I then told him to no longer go in R124's room alone when providing care. V15 was educated on needing to report these kinds of situations. On 8/14/24 at 9:00 am V1 stated that the allegation by R124 against V16 happened over a weekend and was not reported to management until the following Monday, July 22, 2024. On 8/14/24 at 9:00 am V2 stated that they did not report this allegation to the state because R124 is severely confused and because the resident immediately yelled rape as soon as the staff member walked in. Statement dated 7/24/24 by V7 CNA documented this evening around 3:30-4 pm I went into R124's room to get her evening vitals. I said hello and explained what I was there to do. I picked up her left arm and was able to put the cuff up to her elbow and she started to get frustrated and started yanking her arm back. I was finally able to get the cuff off and she swatted at me and started screaming I hit her. I immediately stopped everything and got V17 Social Worker. She came in and talked to her and I went on taking evening vitals. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Statement by V17 Social Worker, undated, documented on 7/24/24 at 4pm. V7 CNA came and stated that R12 said someone hit her. I went to talk to R124, and she said some crazy lady hit her on her right lower arm. She pointed to her wrist area. I asked for her to describe the lady and just said that she was crazy. I asked what happened before that and just said that she wanted to go home. R124 continued to state that we are all liars and that she just wanted to go home. Statement, dated 7/24/24, by V2 DON documented I visited with R124 in her room. I asked R124 how everything was going here. She stated her kids put her here and she doesn't want to be here or understand why. She was asked if anyone had been mean to her, raising their voice to her or touching her. She stated no, she didn't have any problems like that, but everyone likes to lie about her, and she does or says and there is just a bunch of liars here. I talked with R124 and informed her no one was saying anything about her, and no one was lying about her. She smiled and said thank you and laid down. On 8/14/24 at 9:05 am V2 DON stated that the facility did not report the allegation with R124 and V7 to the State and did not suspend V7 pending investigation because R124 is severely confused. 3. R430's face sheet, print date 8/14/24, documented that R430 had diagnoses of hemiplegia, frontotemporal neurocognitive disorder, front-temporal dementia, neuromuscular dysfunction of bladder, and depression. R430's MDS, dated [DATE], documented R430 was completely cognitively intact. V18's statement, dated 1/23/24, documented POA (Power of Attorney) called me stating that a CNA named V14 was touching R430 ways she did not want to be touched. POA stated she did not think anything happened but wanted to let me know. On 8/14/24 at 9:08 am V1 Administrator stated that the facility did not report the allegation to IDPH (Illinois Department of Public Health) nor did they notify the police. 4. R103's face sheet, dated 8/14/24, documented R103 has diagnoses of chronic kidney disease, dementia, depression, hallucinations, glaucoma, osteoarthritis, and macular degeneration. R103's MDS, dated [DATE], documented R103 is severely cognitively impaired. On 8/13/24 at 1:20 pm V2 DON presented a stack of abuse allegations and stated that they were not reported to IDPH (Illinois Department of Public Health) because they determined within 2 hours of the allegations that they were not abuse. During review of these documents, it was noted that R13's allegation documents contained a statement by R103, dated 1/23/24, that was obtained by V17 Social Service. R14's statement documented R103 said when he first took care of him that he fondled his genitals but has never done it again. I reminded him to report anything that makes him feel uncomfortable. He voiced understanding. On 8/13/24 at 3:00 PM V1 stated if we believe it is truly an allegation of abuse then we report it. On 8/14/24 at 8:10 am V1 again stated that they did not report the allegation made by R103 on 1/23/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/14/24 at 12:50 PM V1 stated we do not have a designated Abuse Coordinator. V1 stated that she, V2, and V17 look at each allegation and decide from there if it should be reported or not. V1 stated that she does not know why R124's, R430's, and R103's allegations were not reported to the State. The Long-Term Care Facility Application for Medicare and Medicaid dated 8/20/24 documented 133 residents reside in the facility. The facility Freedom from Abuse, Neglect, Misappropriation and Exploitation Policy, undated, documented it is the policy of Oak Hill to maintain an environment where residents are free from abuse, neglect, exploitation and misappropriation of resident property and all residents, staff, families, visitors, volunteers, and resident representatives are encouraged and supported in reporting any suspected acts of abuse, neglect, misappropriation of resident property, or exploitation. It continues, the Nursing Home Administrator or designees will report abuse to the state agency per Illinois and Federal requirements. It continues, all reports of suspected crime and/or alleged sexual abuse must be immediately reported to local law enforcement to be investigated.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on interview and record review the facility failed to thoroughly investigate allegations of physical and sexual abuse for 3 (R124, R430, R103) residents reviewed for abuse. This failure has the potential to affect all residents in the facility. Findings include: 1.R124's face sheet, dated 8/14/24, documented R124 has diagnoses of dementia, generalized anxiety disorder, hypertension, pulmonary fibrosis, chronic kidney disease, and depression. R124's MDS, dated [DATE], documented R124 is severely cognitively impaired. Statement dated 7/22/24 by V11 RN, ADON (Registered Nurse, Assistant Director of Nursing) documented On Monday, July 22, 2024, I asked V15 RN how R124 was doing. I had heard over the weekend she was having some behavior issues such as hitting, kicking, and refusing medications. V15 stated that this past weekend was terrible, and that R124 would not take medications, was yelling at staff, and then she called her granddaughter on Saturday and told her that the male staff members here rape the residents. I asked V15 who overheard R124 call her granddaughter and V15 stated that she is the one who overheard this conversation. V15 then proceeded to tell me that V16 CNA was taking care of R124 this weekend and she yelled RAPE! very loudly, multiple times while V16 was in the room with her. V15 stated that V16 was scared by this and yelled for a nurse's help. I immediately reported this information to V2 DON. I then called V16 and asked for his side of the story, and his story coincided with V15's story. I explained to him that if anything like this were to happen that he needs to report it to V1 or V2 immediately. I then told him to no longer go in R124's room alone when providing care. V15 was educated on needing to report these kinds of situations. On 8/14/24 at 9:00 am V1 stated that the allegation by R124 against V16 happened over a weekend and was not reported to management until the following Monday, July 22, 2024. On 8/14/24 at 9:00 am V2 stated that they did not report this allegation to the state because R124 is severely confused and because the resident immediately yelled rape as soon as the staff member walked in. V2 stated that the facility did not notify the police, did not question other employees, and they did not examine R124's genitalia. Statement dated 7/24/24 by V7 CNA documented this evening around 3:30-4 pm I went into R124's room to get her evening vitals. I said hello and explained what I was there to do. I picked up her left arm and was able to put the cuff up to her elbow and she started to get frustrated and started yanking her arm back. I was finally able to get the cuff off and she swatted at me and started screaming I hit her. I immediately stopped everything and got V17 Social Worker. She came in and talked to her and I went on taking evening vitals. Statement by V17 Social Worker, undated, documented on 7/24 at 4 pm. V7 CNA came and stated that R124 said someone hit her. I went to talk to R124, and she said some crazy lady hit her on her right lower arm. She pointed to her wrist area. I asked for her to describe the lady and she just said that she was crazy. I asked what happened before that and just said that she wanted to go home. R124 continued to state that we are all liars and that she just wanted to go home. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Written statement, dated 7/24/24, by V2 DON documented I visited with R12 in her room. I asked R124 how everything was going here. She stated her kids put her here and she doesn't want to be here or understand why. She was asked if anyone had been mean to her, raising their voice to her or touching her. She stated no, she didn't have any problems like that, but everyone likes to lie about her, and she does or says and there is just a bunch of liars here. I talked with R124 and informed her no one was saying anything about her, and no one was lying about her. She smiled and said thank you and laid down. On 8/14/24 at 9:05 am V2 DON stated that the facility did not investigate the allegation with R124 and V7, did not suspend V7 pending investigation, did not question other residents and employees, and did not conduct nor document a physical assessment of R124 because R124 is severely confused. 2. R430's face sheet, print date 8/14/24, documented that R430 had diagnoses of hemiplegia, frontotemporal neurocognitive disorder, front-temporal dementia, neuromuscular dysfunction of bladder, and depression. R430's MDS, dated [DATE], documented R430 was completely cognitively intact. V18's written statement, dated 1/23/24, documented POA (Power of Attorney) called me stating that a CNA named V14 was touching R430 ways she did not want to be touched. POA stated she did not think anything happened but wanted to let me know. R430's progress note, dated 1/23/24 at 10:56 am, documented POA [NAME] called and stated that resident reported that CNA V14 was touching resident where she did not want to be touched. This nurse reported to ADON V11 about situation. On 8/14/24 at 9:08 am V1 Administrator stated that the facility did not question R430 regarding the allegation, the facility did not report the allegation to the State, the facility did not suspend nor remove V14 CNA from the schedule because he is agency, they did not question other staff regarding the allegation, nor did they notify any authorities regarding the allegation. 3. R103's face sheet, dated 8/14/24, documented R103 has diagnoses of chronic kidney disease, dementia, depression, hallucinations, glaucoma, osteoarthritis, and macular degeneration. R103's MDS, dated [DATE], documented R103 is severely cognitively impaired. On 8/13/24 at 1:20 pm V2 DON presented a stack of abuse allegations and stated that they were not reported to IDPH (Illinois Department of Public Health) because they determined within 2 hours of the allegations that they were not abuse. During review of these documents, it was noted that R430's allegation documents contained a statement by R103, dated 1/23/24, that was obtained by V17 Social Service. R103's statement documented R103 said when he first took care of him that he fondled his genitals but has never done it again. I reminded him to report anything that makes him feel uncomfortable. He voiced understanding. On 8/13/24 at 3:00 PM V1 stated that they did not complete an investigation into the allegation made by R103 on 1/23/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/14/24 at 8:10 am V1 again stated that they did not conduct an investigation, nor did they report the allegation made by R103 on 1/23/24. V1 then stated that she asked R103 this morning if he has ever been touched inappropriately and he stated no. On 8/14/24 at 12:50 PM V1 stated that the facility does not have a designated Abuse Coordinator. V1 stated that she, V2, and V17 look at each allegation and decide from there if it should be investigated or not. V1 stated she does not know why R124's, R430's, and R103's allegations were not investigated. The Long-Term Care Facility Application for Medicare and Medicaid dated 8/20/24 documented 133 residents reside in the facility. The facility Freedom from Abuse, Neglect, Misappropriation and Exploitation Policy, undated, documented it is the policy of Oak Hill to maintain an environment where residents are free from abuse, neglect, exploitation and misappropriation of resident property and all residents, staff, families, visitors, volunteers, and resident representatives are encouraged and supported in reporting any suspected acts of abuse, neglect, misappropriation of resident property, or exploitation. It continues, the Nursing Home Administrator or designees will report abuse to the state agency per Illinois and Federal requirements. It continues, it is the policy of Oak Hill that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation, and misappropriation of property) are promptly and thoroughly investigated. The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately upon identification of alleged abuse. A root cause investigation and analysis will be completed. The information gathered is given to administration. a. Investigation of abuse: When an incident or suspected incident of abuse is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include: 1. Who was involved 2. Residents' statements a. For non-verbal residents, cognitively impaired residents or residents who refuse to be interviewed, attempt to interview resident first. If unable, observe resident, complete an evaluation of resident behavior, affect and response to interaction, and document findings. 3. Resident's roommate statements 4. Involved staff and witness statements of events 5. A description of the resident's behavior and environment at the time of the incident 6. Injuries present including a resident assessment 7. Observation of resident and staff behaviors during the investigation. It continues, all reports of suspected crime and/or alleged sexual abuse must be immediately reported to local law enforcement to be investigated.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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** 35156 Based on interview and record review the Facility failed to ensure resident was being properly supervised and in a clutter-free environment that was free of hazards for 1 of 5 residents (R80) reviewed for falls in the sample of 56. This failure resulted in R80 who had a history of falls tripping over a chair or bedside table in the sunroom, requiring seven stitches. Findings include: R80's Physician Order Sheet for August 2024 documents a diagnosis of Alzheimer disease, atrial fibrillation, overweight retention of urine, generalized anxiety disorder, myocardial infarction, major depressional disorder, type 2 diabetes mellitus without complications. R80's Minimum Data Set, dated dated dated [DATE] documents R80 was severely impaired for cognition for activities of daily living. R80's Care Plan documents he has a history of falls and had fallen on 12/14/2023, 1/28/2024, 2/16/2024 and 3/3/2024. R80's Care Plan with start date of 8/23/2023 documents, Problem: Increased susceptibility to falling that may cause physical harm r/t (related to) history of falls, age, use of assistive devices, visual or hearing difficulties, incontinence, impaired physical mobility, cognitive impairment, w/c (wheelchair) use, weakness, poor safety awareness, poor standing balance, poor insight into deficits, impulsiveness. 3/26/24 fall in Sunroom minor injury, RCA (root cause analysis) tripped on chair IDT (interdisciplinary team) sunroom rearranged non-essential furniture removed. R80's Progress Notes dated 3/26/2024 at 6:55 PM, At approximately 6:00 PM resident was walking in sunroom, tripped on chair and fell on to R (right) side. Deep laceration noted to R eyebrow - unable to measure d/t (related to) amount of sanguineous drainage (bloody discharge). 1.5cm x 0.5cm skin tear noted to Right elbow - wound cleansed and dressing applied. Staff assisted resident to couch and applied pressure to Right eyebrow wound. Resident able to move all extremities WNL (within normal limits) but unable to voice pain at this time. Verbal responses at baseline. Physician notified and assessed resident. N.O. (new order) send resident to ER (emergency room). Unable to reach POA (power of attorney), left message and then contacted daughter, who spoke with V26, Family R80 and agreed to send res to (Hospital) EMS (emergency medical services) contacted. R80's Incident Report dated 3/26/2024 at 6:00 PM, Resident was walking in sunroom, tripped on chair and fell on to right side. Resulting in right eyebrow laceration and skin tear to right elbow. R80's Post Management Post Fall Assessment Tool dated 3/26/2024 documents, Laying on right side on floor of sunroom. Staff to assist resident when ambulating. Sunroom assessed, rearranged, and all nonessential furniture removed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R80's Progress Notes dated 3/26.2924 at 11:26 AM, Resident returned at approximately 11:30 PM, via ambulance. Bruising noted to right eye lid, 7 stitches intact. Resident appears to leaving the area alone. R80's Progress Notes dated 3/29/2024 at 9:54 AM, Patient continues to be on observation related to follow up fall day #3 and orders related to Zoo {sic}. Bruising continues to right eyebrow, stitches intact. R80's Progress Notes dated 8/23/2024 at 11:59 AM, V22, Registered Nurse (RN) Nurse stated, (R80) was out in the sunroom the day he fell . He used to be ambulatory and had a decline and he was in a wheelchair. We are thinking one of his feet got hooked on the chair or side table and got a gauge on eyebrow and fell out of the wheelchair. He was sent out to the hospital where he got stitches. R80's Hospital discharge Records dated 3/26/2024 documents, You have 7 stitches that will need to be removed in 7-10 days. On 8/23/2024 at 12:30 PM, V27, Nurse Practitioner stated, (R80) had a heart attack before thanksgiving and did have a decline in health. I would expect areas like the sunroom to be clutter free and free of hazards. It was unfortunate that he fell . The Fall Policy dated 10/27/2023 documents, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level or risk to minimize level of risk to minimize the likelihood of falls. A 'fall' is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force (e.g. resident pushes another resident). The even may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33110 Based on observation, interview and record review the facility failed to ensure infection control procedures were in accordance with current standards of practice for Covid-19. This failure has the potential to affect all 133 residents residing in the facility. Findings Include: On 8/20/24 the facility provided a document titled, Covid Positive which noted R113 and R51 are the resident's currently residing in the facility who are positive for Covid-19 at this time. 1. On 8/20/2024 at 12:00 PM R51 was observed lying in bed, as well as R12 sitting up in a chair within the same room. No masks being worn by either resident and the privacy curtain was not observed as being pulled to separate the residents. R12 stated My roommate has COVID. She really is not feeling well. I had COVID in 2021 and was very sick. I was not offered a mask or to move rooms. I know how to take the necessary precautions. Despite R12's statement of knowing how to take necessary precautions, no precautions that were being taken were expressed. R51's Face Sheet documents an admitted [DATE]. Diagnosis include Sepsis due to Enterococcus, Acute hypoxia due to respiratory failure, Acute kidney failure, Hypo-osmolality, hyponatremia, Chronic lymphocytic leukemia of B-cell type not having achieved remission, etc . R51's Minimum Data Set, MDS, dated [DATE] documents R51 is moderately cognitively impaired and requires partial/moderate assist with mobility. R51's Care Plan updated 8/19/2024 Problem: At risk for invading viral organisms related to COVID pandemic as evidenced by advanced age, community living setting, comorbidities. 6 feet apart if in outbreak status. Will test per Illinois Department of Public Health, IDPH/ facility policy if in outbreak. 8/19/24 Positive for Covid. R51'a progress notes dated 8/20/2024 at 6:30AM documents This nurse changed R51's dressing due to leaking. R51 continues isolation related to positive COVID results. Vital signs stable. No signs or symptoms noted. R51 turned every 2 hours. No complaints of pain or discomfort currently, call light within reach. R51's Covid Rapid Test documented on 8/19/24 at 5:30 AM, a positive test for Covid-19 with symptoms present being listed as a cough. R12's Face Sheet documents an admitted [DATE]. Diagnosis include Gastrointestinal Hemorrhage, Type 2 Diabetes, Chronic Kidney Disease, Hypertensive heart, and Chronic Kidney Disease without heart failure. R12's MDS updated 7/8/2024 documents R12 has no cognitive impairments and requires supervision/touching assist with mobility. R12's COVID rapid test results dated 8/19/2024 documents negative result. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145445	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hill	623 Hamacher Street Waterloo, IL 62298

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/21/24 at 10:25 AM, V1 (Administrator) stated that resident's who have tested positive for Covid-19 are encouraged to utilize a mask and/or quarantine in their room, but are not required to. V1 stated Covid-19 positive residents are allowed to exit their room and choose not to wear personal protective equipment as it is part of their resident rights. V1 confirms Covid positive residents may interact with non Covid-19 positive residents. V1 stated social distancing is encouraged in common areas as the facility's effort to help protect resident's who have not tested positive for Covid-19. V1 also stated that if space allows, if one resident has tested positive for Covid-19 in a room and the room mate is negative, the resident's would be moved to separate rooms. V1 confirms that the facility is not at full capacity at this time. On 8/21/24 at 11:15 AM, V20 (Infection Preventionist) stated it is the facility's expectation to follow the Center for Disease Control (CDC) guidelines regarding Covid-19. V20 stated she has received complaints from staff regarding resident's who are positive for Covid-19 being allowed to leave their room without personal protective equipment. V20 stated that staff were notified that it was the resident's right to leave their room and education should be provided to the resident, encouraging them to quarantine and/or utilize source control. V20 confirmed resident's who are positive for Covid-19 are placed on contact and droplet isolation. Facility policy updated 2024 states Residents with suspected or confirmed SARS-CoV-2 infection should be placed in a single person room with door kept closed, if safe to do so, and a dedicated bathroom if possible. If cohorting, only residents with the same respiratory pathogen should be housed in the same room. Review of the not dated policy provided by the facility titled, COVID-19 Prevention, Response and Reporting documents, It is the policy of this facility to ensure that appropriate interventions are implemented to prevent the spread of COVID-19 and promptly respond to any suspected or confirmed COVID-19 infections. The Centers for Disease Control titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (Covid-19) Pandemic, dated March 18, 2024 documents the following: Source control refers to use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing .Source control is recommended for individuals in healthcare settings who: Have suspected or confirmed SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2) infection or other respiratory infection .or had close contact (patients and visitors) or a highter-risk exposure (HCP) with someone with SARS-CoV-2 infection, for 10 days after their exposure. Place a patient with suspected or confirmed SARS-CoV-2 in a single-person room. The door should be kept closed (if safe to do so) .Limit transport and movement of the patient outside of the room to medically essential purposes. The Long-Term Care Facility Application for Medicare and Medicaid dated 8/20/24 documented 133 residents reside in the facility. 36969 42834