STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145464	A. Building B. Wing	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hammond-Henry District Hsp	600 North College Avenue Geneseo, IL 61254

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 - Many	Provide and implement an infection prevention and control program. 33970 Facility Failure resulted in two deficient practices. A. Based on observation, interview and record review the facility failed to monitor the active infections of the unit. This failure has the potential to affect 34 resident who currently reside in the facility. B. The facility failed to perform perineal care in a way to prevent possible cross contamination for one resident (R1) of three reviewed for perineal care. Findings Include: A. The Facility's Departmental Responsibilities for Infection Control Policy document The Infection Control Practitioner (ICP) performs most aspects of the Infection Control Program decided upon by the Infection Control Committee. Time is devoted to surveillance and implementing procedures of reporting infections, staff education, employee health assisting in the development of policies and procedures, resolving problems related to infection control by assuring that isolation practices are working well and doing paperwork. The Facility's undated Antibiotic Stewardship Program documents The ASP (Antibiotic Stewardship Program) team will review infections and monitor antibiotic usage patterns on a regular basis and address an issue regarding antibiotic use if identified. ASP activities reflect the scope and complexity of the services provided (at the facility) Such activities include: observation of trends, retrospective review of antimicrobial use and susceptibility, monthly monitoring of antibiotic days of therapy per 100 patient days, monthly monitoring of defined daily dose of levofloxacin per 100 patient days. On 01/02/2024 at 10:00 AM V3 (Registered Nurse/Assistant Director of Nursing) stated that the facility pharmacy monitors the use of some of the antibiotics and will send memos. V3 stated there was no monitoring of infections per each resident, what the antibiotic was ordered for, what the symptoms were, when the symptoms began, what antibiotic the resident was on and when the symptoms were resolved for each resident. V3 also stated that there was no tracking and trending of where the infections were at in the facility or if there were an increase in any certain type of infections. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/02/24 at 1:30 PM V2 (Registered Nurse/Director of Nursing) confirmed that there was no active infection control monitoring for the facility itself for infections and/or antibiotic use. Pharmacy does antibiotic reports for QA (Quality Assurance) reports but nothing on an ongoing basis that I am aware of. Throughout the survey, V14 (Registered Nurse/Infection Preventionist) was not available for interview. The facility's room roster listed 34 residents who currently reside in the facility. B. The facility's undated Hand Hygiene policy all employees will use effective hand hygiene. Hand washing is considered the single most important procedure for preventing the spread of microorganisms that may lead to infection. Hand Hygiene is to be completed at each of the 5 moments, but not limited to, according to the World health Organization, regardless of whether gloves are used or not. Hand Hygiene can occur via hand washing with soap and water or use of alcohol-based hand rub. 1. Before touching a patient 2. before clean/aseptic procedure 3. after body fluid exposure risk 4. after touching a patient 5. after touching patient surroundings. The facility's undated Hand Hygiene policy states that Gloves are to be discard/changed after use on a contaminated body site before moving to a clean body site. On 01/03/24 at 10:15 AM both V2 (Registered Nurse/Director of Nursing) and V3 (Registered Nurse/Assistant Director of Nursing) that the video dated 11/27/24 at 12:07 AM starts as V6 (CNA) is on R1's right side with a towel/drape of some sort on the bedside table with wipes already laid out in a row. V15 (CNA) is on R1's left side and positioning and calming R1. When the video started both V6 (CNA) and V15 (CNA) were already in place with gloves on. V6 (CNA) unfastened the front of R1's incontinent brief and tucked it between her legs. V6 then removed her gloves and performed hand hygiene with hand sanitizer and regloved. V7 (LPN) can then be seen walking into the room with gloves already on and reached into her shirt pocket and removed a tube of cream. V7 opened the tube with her left hand and squeezed some cream into her left hand and applied the cream to R1's front perineal area. V7 (LPN) then puts the tube of cream back into her pocket and moves to the other side of the bed and reaches back into her shirt pocket and removes the tube of cream and opens it with her left hand and squeezes some onto her left hand and applies it to R1's buttocks. V7 then recaps the tube of cream and puts in back in her pocket and the video then stops before the rest of the incontinent care by the CNAs can be observed. On 01/02/24 at 10:15 AM both V2 (Registered Nurse/Director of Nursing) and V3 (Registered Nurse/Assistant Director of Nursing) both confirm that V7 should not have reached into her shirt pocket with gloved hands to retrieve the tube of cream and both V2 and V3 stated that V7 (LPN) should have applied R1's cream to her front perineal area then removed her gloves and performed hand hygiene of some sort and regloved prior to applying the cream to R1's buttocks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/03/24 at 10:30 AM both V2 (Registered Nurse/Director of Nursing) and V3 (Registered Nurse/Assistant Director of Nursing) confirmed that the video dated 12/23/24 at 6:28 PM shows V6 (Certified Nurse Aid) and V9 (Certified Nurse Aid) enter R1's room and perform hand hygiene with hand sanitizer and then donned gloves. V9 (CNA) had her towel/drape on the bedside table with the wipes already pulled out of the package and lined up on the assumed clean towel/drape. V6 comforted R1 while V9 (CNA) used a wipe and wiped R1's left groin, threw it away, used another clean wipe for R1's right groin, threw it away and then used another clean wipe while cleaning R1's pessary area (vaginal slit area) and then threw it away. V9 then changed gloves without any hand hygiene. V10 (Registered Nurse) can then be seen entering the room, performing hand hygiene with hand sanitizer and then donned gloves. V10 opened a tube of cream that she had laid on the bed and could be seen obviously touching the tip of the tube while squeezing some cream onto her fingers and left the tube open and in her left hand. V10 (RN) then applied some cream to R1's groin area, squeezed more cream onto the same fingers and hand while obviously touching the tip of the tube and applied more to R1's perineal area. V10 (RN) then moved to the other side of the bed and V6 (CNA) rolled R1 so that V10 could squeeze more cream onto the same glove and same finger/hand and apply it to R1's buttocks. V9 (CNA) then removed R1's incontinent brief and incontinent pad and removed her gloves and performed hand hygiene and completed R1's care without any further cross contamination of R1 or the environment. On 01/03/24 at 10:30 AM both V2 (RN/DON) and V3 (RN/ADON) confirmed that when V9 (CNA) changed her gloves after she had wiped R1's front perineal area that she should have performed hand hygiene of some sort. Both V2 and V3 confirmed that V10 (RN) should not have touched the tip of tube of cream with her fingers at any time and that once V10 applied the cream to R1's front perineal area she should have removed her gloves, performed hand hygiene and donned new gloves before applying the cream to R1's buttocks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/03/24 at 11:00 AM both V2 (Registered Nurse/Director of Nursing) and V3 (Registered Nurse/Assistant Director of Nursing) confirmed that the video dated 12/31/24 at 12:18 AM shows V6 (Certified Nurse Aide), V7 (Licensed Practical Nurse) and V8 (Certified Nurse Aid) all enter R1's room and don gloves. V6 (CNA) and V8 (CNA) position R1, V6 unfastened the front of R1's incontinent brief and pushed it in between R1's legs and then without changing gloves or hand hygiene, turned to the bedside table and pulled wipes out of the wipe package. V6 stated she did not have enough wipes to perform incontinent care at that time so V8 left the bedside with her original set of gloves on and went to the bathroom door and opened it and went inside. A couple seconds later V8 returned to the bedside with a new package of wipes that V6 then opened and put a couple on a towel on the bedside table. V6 then used her gloved hands to open R1's bedside drawers but did not state out loud what she was looking for. V6 then used her right hand to wipe the top of R1's pubic area and threw it away. V6 used another wipe and wipe on R1's left groin area, pulled the wipe out, flipped it inside out and wiped R1's right groin and threw it away. V6 then used a new wipe to cleanse R1's urethra. V6 then took her gloves off and put new ones on without performing any hand hygiene. V7 (LPN) then reached into her shirt pocket with her gloved hand and pulled out a tube of cream. V7 opened the tube with her gloved left hand and squirted some cream on her left fingers while obviously touching the tip of the tube before resealing it and putting it back into her shirt pocket. V7 then applied the cream to R1's right and left groin areas. R1 was rolled to the side and V6 (CNA) wiped her with a wipe and then stated, I need to dry her and wiped her with another type of cloth. V7 then pulled the tube of cream out of her shirt pocket and opened it with her right hand and squeezed some cream on her right fingers while obviously touching the tip of the tube and then closed it and dropped it back in her pocket and then applied to the cream to R1's buttocks. V6 (CNA) then pulled out the incontinent pad and rolled up incontinent brief with her gloved hand and then used the same gloved hand to get the new incontinent pads and briefs and apply those to R1. On 01/03/24 at 11:00 AM both V2 (RN/DON) and V3 (RN/ADON) both confirmed that after V6 unfastened R1's incontinent brief and pushed it between her legs that V6 (CNA) should not have touched the wipe package or the drawers. Both V2 and V3 stated that V8 (CNA) should not have kept her gloves on when she left the bedside to get more wipes out of the bathroom. Both confirmed that V8 should have removed her gloves, performed hand hygiene of some sort, obtained the wipes and gave them to V6 (CNA) then V8 (CNA) should have performed hand hygiene and regloved. Both V2 and V3 confirmed that V7 (LPN) should not have reached into her pocket with a gloved hand and that V7 shouldn't have touched the tip of the tube. Both V2 and V3 verified that V7 (LPN) should have removed her gloves, performed hand hygiene and regloved before she put the cream on R1's buttocks. V2 (RN/DON) and V3 (RN/ADON) both confirmed that V6 (CNA) should have removed her gloves and performed hand hygiene after she removed the soiled incontinent pad and incontinent brief before she applied the clean incontinent pad and incontinent brief.