

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145470	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2026
NAME OF PROVIDER OR SUPPLIER Heritage Health-Hoopeston		STREET ADDRESS, CITY, STATE, ZIP CODE 423 North Dixie Highway Hoopeston, IL 60942	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to sanitarly store respiratory equipment when not in use. This failure affects four residents (R5, R27, R40, and R74) out of five residents reviewed for respiratory care on the sample list of 41. Findings include: 1. On 5/19/26 at 2:17 PM, R27's Continuous Positive Airway Pressure (CPAP) face mask, with the supply tubing connected to the CPAP machine on top of the bureau, was inside the slightly open top drawer of R27's bedside bureau, unprotected from contamination due to other items in the drawer including a second older CPAP machine, 2 old used partially full concentrator humidifier bottles dated 7/9/25 and 7/17/25, and a box of electric shaver head replacements. R27's Medical Diagnoses List dated 5/20/26 documents R27 experiences medical conditions including Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure, Shortness of Breath, Congestive Heart Failure, Anxiety, Hypertension, and Obstructive Sleep Apnea. On 5/20/26 at 1:28 PM, V3, Infection Preventionist, stated V3 expects the CPAP masks to be stored hanging up to dry after daily cleaning, or to be inside of a plastic bag or clean drawer, not inside of a drawer with other items in it. R27's Physician Order Sheet dated 5/20/26 documents daily CPAP care to include: After removing in the am, empty humidifier, rinse, and air dry. Rinse mask and tubing with tap water, hang to dry. 2. On 5/19/26 at 2:04 PM, R40's CPAP face mask, connected to the machine by hoses, was sitting on top of R40's bedside bureau, unprotected from contamination. R40 stated the CPAP face mask was the type that fits directly over R40's nose. R40's Medical Diagnoses List dated 5/20/26 documents R40 experiences medical conditions including Obstructive Sleep Apnea and Insomnia. On 5/20/26 at 1:28 PM, V3, Infection Preventionist, stated V3 expects the CPAP masks to be stored hanging up to dry after daily cleaning, or to be inside of a plastic bag or clean drawer, not on top of the bureau. R40's Physician Order Sheet dated 5/20/26 documents daily CPAP care to include rinsing with warm tap water and hanging to dry. 3. R5's Minimum Data Set (MDS) dated [DATE] documents R5 as moderately cognitively impaired. R5's Electronic Medical Record (EMR) documents R5's medical diagnoses as Chronic Pain, Chronic (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Obstructive Pulmonary Disease (COPD), Dementia and Chronic Heart Failure. R5's Physician Order Sheet (POS) dated May 2026 documents a physician order starting 3/24/26 to administer Arformoterol Tartrate Inhalation Nebulization Solution 15 micrograms (mcg)/2 milliliter (ml) orally via nebulizer two times per day related to Chronic Obstructive Pulmonary Disease (COPD). On 5/19/26 at 1:00 PM R5's Nebulizer mask was lying face down on R5's bed. On 5/20/26 at 2:45 PM R5's Nebulizer mask was lying face down on R5's recliner chair. On 5/21/26 at 9:00 AM R5's Nebulizer mask was lying face down on a pillow on R5's bed. On 5/21/26 at 8:50 AM V6 Registered Nurse (RN) stated V6 is R5's nurse routinely and normally 'just lays the mask on (R5's) bed or on top of (R5's) machine'. V6 RN stated R5's Nebulizer mask is 'never' put into a bag or stored in any way to prevent cross contamination. On 5/20/26 at 1:25 PM V3 Infection Preventionist (IP) stated Continuous Positive Airway Pressure (C-PAP) and Nebulizer masks should be air dried and then stored in a bag in between uses. 4. R74's diagnosis list (5/21/26) documents R74 has Chronic Obstructive Pulmonary Disease (COPD). R74's Physician Orders (5/20/26) documents the following orders: Albuterol Sulfate (bronchodilator) Inhalation Nebulization Solution, 2.5 milligrams/0.5 milliliters (mg/ml), 3 ml inhale orally via nebulizer two times a day for SOB (shortness of breath), wheezing related to COPD and Albuterol Sulfate Inhalation Nebulization Solution, 2.5 ml/0.5 mg, 3 ml inhale orally via nebulizer as needed (PRN) for SOB (shortness of breath), wheezing related to COPD may give twice a day PRN. This same record further documents cleanse nebulizer machine, change tubing/mask and bag and date every night shift every Sunday per protocol. R74's May 2026 Medication Administration Record documents R74 receives Albuterol nebulizer treatments at 5:00 a.m., and 4:00 p.m. On 5/19/2026 at 10:45 a.m., R74 was sitting in a recliner with R74's nebulizer machine, mouthpiece, and tubing sitting on top of R74's overbed table. R74 stated R74 receives nebulizer treatments twice a day via the mouthpiece. On 5/20/2026 at 1:56 p.m., R74's nebulizer machine, mouthpiece, and tubing were sitting on top of R74's overbed table. On 5/20/26 at 1:28 p.m., V3 IP stated R74's nebulizer mouthpiece and tubing should be cleaned after each use, placed in a bag, and not laying on the overbed table.		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to allow one (R62) resident to utilize their own Continuous Positive Airway Pressure (C-PAP) machine from their home environment out of one resident reviewed for resident rights in a sample list of 41 residents. Findings include: R62's undated Face Sheet documents R62 was admitted to the facility on [DATE]. R62's Minimum Data Set (MDS) dated [DATE] documents R62 as cognitively intact. R62's Physician Order Sheet (POS) dated May 2026 documents a physician order starting 4/1/2025 to assist R62 with placing R62's Continuous Positive Airway Pressure (CPAP) on at bedtime. Remove in the morning (AM) when awake. Settings minimum pressure 8, maximum pressure 13 and ramp per R62's preference. On 5/19/26 at 10:45 AM R62 stated staff told R62 that R62 cannot use R62's own C-PAP machine from home because ?they have a contract with the C-PAP company'. R62 stated there was nothing wrong with R62's home C-PAP machine and felt more comfortable with it. R62 stated R62 is not familiar with the facility provided machine and would like to have R62's own machine to use. R62 stated R62 does not understand why R62 cannot have R62's own machine and is being 'forced' to use the facility machine. On 5/20/26 at 2:20 PM V1 Administrator stated the facility has a contract with a respiratory company who will provide all of the C-PAP and Nebulizer machines for the residents. V1 Administrator stated it is easier for the facility to monitor the machines and if there is a problem with a machine then the facility can just call the company without having to try to determine which company the resident uses. V1 confirmed it could be considered a resident right's issue. The undated Illinois Long Term Care Ombudsman Program Resident Rights for people in Long Term Care Facilities pamphlet documents residents have the right to keep and use your own property.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete a significant change Minimum Data Set Resident Assessment for a resident with a significant decline in multiple areas of health status. This failure affects one resident (R11) out of one reviewed for activities of daily living on the sample list of 41. Findings include: R11's Minimum Data Set (MDS) Resident Assessment Instrument dated 12/31/25 documents R11 had a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15, indicating severe cognitive impairment. This same MDS documents R11 required moderate assistance from staff for bed mobility to roll from side to side, to go from lying to sitting position, from sitting to lying position, and from sitting to standing position. This MDS documents R11 required moderate staff assistance to accomplish a transfer from the bed to a chair, and from a chair to the shower. This MDS documents R11 weighed 146 pounds. This MDS documents R11's skin was free of pressure ulcers, and R11 had no behaviors of rejecting care. This MDS documents R11 was frequently incontinent of bladder and always continent of bowel. R11's MDS dated [DATE] documents R11 had a mild cognitive decline to a BIMS score of 1 out of a possible 15. This MDS documents R11 required maximum staff assistance to accomplish bed mobility to roll side to side, to go from sitting to lying, from lying to sitting, and from sitting to standing. This MDS documents R11 was dependent upon staff to accomplish a transfer from the bed to a chair, and from a chair to the shower. This MDS documents R11 weighed 130 pounds. This MDS documents R11 now had a stage 2 pressure ulcer on R11's left heel and was exhibiting behaviors of rejecting care. This MDS documents R11 was frequently incontinent of both bladder and bowel. Comparing these two MDS assessments, R11 experienced a mild cognitive decline, significant functional ability declines in six areas, significant weight loss, exhibited a new behavior of rejecting care, acquired a new pressure ulcer, and became incontinent of bowel. R11's Nurses Progress Notes dated 1/9/26, 1/31/26, 3/10/26 and 3/20/26 confirm R11 had experienced significant weight loss, with each note including an interdisciplinary team review. R11's Nurses Progress Notes dated 1/14/26 document R11 hitting and kicking at staff making R11 unapproachable. The 1/28/26 Nurses Progress Note documents R11 being combative with staff. R11's Nurses Progress Notes dated 2/19/26 documents a declination of a pharmacy recommendation to attempt a dosage reduction in R11's psychoactive medications due to ongoing behaviors and agitation. R11's Nurses Progress Notes dated 3/31/26 documents R11 developed an intact blister (stage 2 pressure ulcer) on R11's left heel. R11's Physician Order Sheet dated 5/21/26 documents in addition to the decline in cognitive, behavioral, and functional abilities, R11 required changes in both of R11's insulin prescriptions during the same period from 12/31/25 to 4/1/26. R11's long-acting insulin was changed from 13 units daily to 6 units daily on 1/15/26. R11's fast acting insulin sliding scale (insulin administered according to the level of blood glucose) was changed on 1/15/26 to half of the previous doses. R11's prior sliding scale was ordered by R11's physician as a blood glucose level of zero to 180 required no administration of insulin, a level of 181 to 230 required 2 units injection of insulin, 231 to 280 required 4 units, 281 to 330 required 6 units, 331 to 380 required 8 units, and 381 to 430 required 10 units. R11's new physician orders for fast acting insulin referenced the same glucose level ranges but 1 unit, 2 units, 3 units, 4 units, and 5 units for the incremental required doses, respectively. The current Centers for Medicare and Medicaid Services Long Term Care Facility Resident Assessment Instrument 3.0 Users Manual dated October 2025 documents on page 45: A significant change is a major decline or improvement in a resident's status that:1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting;2. Impacts more than one area of the resident's health status; and3. Requires interdisciplinary review and/or revision of the care plan. On 5/20/26 at 2:36 PM, V5, Minimum Data Set Coordinator, stated V5 triggers a review for a significant change if a resident has a fall or a significant decline. V5 confirmed R11 would qualify for a significant change (continued on next page)		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	change MDS. V5 stated R11 is in therapy right now (staff intervention). V5 further stated V5 has a copy of the MDS User Manual. R11's current Care Plan documents new revisions in the time period between 12/31/25 and 4/1/26. On 3/25/26 to keep R11's fingernails short to avoid scratching R11's self. On 3/30/26 a revision to an existing intervention to place a censor pad alarm in R11's bed to alert staff when resident gets up by R11's self, check batteries at start of your shift. On 3/30/26 a new intervention to place R11's bed in the low position. On 1/6/26 a new intervention documenting R11 is on our 1:1 (one to one) program, R11 participates in sensory work with activity assistants, R11 excels the most when working with textures, taste and sound, we work with resident with spirituality, mental stimulation, self-help, creativity, games, socialization and sensory/cognitive stimulation.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview, and record review, the facility failed to complete an accurate Minimum Data Set Resident Assessment Instrument to include the use of non-invasive ventilators (CPAP, Continuous Positive Airway Pressure). This failure affects two residents (R27 and R40) out of five residents reviewed for respiratory services on the sample list of 41. Findings include: 1. On 5/19/26 at 2:17 PM, R27's Continuous Positive Airway Pressure (CPAP) face mask, with the supply tubing connected to the machine, was inside the slightly open top drawer of R27's bedside bureau. R27's Physician Order Sheet dated 5/20/26 documents for nursing staff to refill the CPAP machine with distilled water every night shift; CPAP Daily Care: After removing in the am, empty humidifier, rinse and air dry, rinse mask and tubing with tap water, hang to dry every day shift; and Apply CPAP at HS (hour of sleep), remove in am. CPAP pressure: 18 RAMP (setting that gradually increases air pressure as the patient falls asleep). R27's Care Plan initiated 3/11/25 documents R27 utilizes a CPAP related to Obstructive Sleep Apnea. R27's Minimum Data Set (MDS) Resident Assessments dated 12/9/25 and 2/24/26, Section O, document a coding for no non-invasive ventilators or CPAP use. On 5/20/26 at 2:36 PM, V5, Minimum Data Set Coordinator, confirmed R27 uses a CPAP machine and stated V5 was surprised R27's MDS was not coded for the use of the CPAP. V5 acknowledged answering no for the non-invasive ventilators disables the option to code for the CPAP. 2. On 5/19/26 at 2:04 PM, R40's CPAP face mask, connected to the machine by hoses, was sitting on top of R40's bedside bureau. R40's Physician Order Sheet dated 5/20/26 documents for nursing staff to apply the CPAP machine at night when R40 is sleeping and remove in AM, pressure settings 4-10; fill CPAP humidifier with distilled water every evening shift; CPAP daily care: Rinse humidifier, tubing and mask with warm tap water and hang to dry every day shift. R40's Care Plan initiated 1/5/26 documents a focus area for CPAP/ BIPAP (Bilevel Positive Airway Pressure) therapy. R40's Minimum Data Sets dated 1/11/26 and 4/14/26 Section O, document a coding for no non-invasive ventilators or CPAP use. On 5/20/26 at 2:36 PM, V5, Minimum Data Set Coordinator, confirmed R40 uses a CPAP machine and stated V5 was surprised R40's MDS was not coded for the use of the CPAP. V5 acknowledged answering no for the non-invasive ventilators disables the option to code for the CPAP.		

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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** Based on interview and record review the facility failed to follow their Antibiotic Stewardship policy for one (R2) resident out of one resident reviewed for Antibiotic Stewardship in a sample list of 41 residents. Findings include: R2's undated Face Sheet documents R2 admitted to the facility on [DATE] and readmitted on [DATE]. R2's Electronic Medical Record (EMR) documents R2's medical diagnoses as history of Urinary Tract Infection (UTI), Low Back Pain, Mixed Incontinence, Cystitis, Urgency of Elimination, Overactive Bladder and Chronic Pain. R2's Physician Order Sheet (POS) dated May 2026 documents a physician order starting 8/4/2025 and ending 8/4/2026 to administer Bactrim 400-80 milligrams (mg) half a tablet every Monday, Wednesday and Friday morning for recurrent Urinary Tract Infection (UTI) for 12 months. R2's Medication Administration Record (MAR) dated May 2026 documents R2 was administered Bactrim 400-60 mg on May 1, 4, 6, 8, 11, 13, 15, 18 and 20. On 5/21/26 at 2:00 PM V3 Infection Preventionist (IP) stated the facility Antibiotic Stewardship program's focus is to reduce the amount of time a resident is on an antibiotic and to not administer Antibiotics unnecessarily. V3 IP stated the facility follows McGeer's Criteria to determine if a resident has a Urinary Tract Infection (UTI) along with the results of a Urinalysis with Culture and Sensitivity (C&S). V3 IP stated administering long term antibiotics to R2 does not follow the facility Antibiotic Stewardship policy. The undated facility policy titled Antibiotic Stewardship documents the policy of this facility is to implement an Antibiotic Stewardship Program (ASP) which will promote appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. This policy has the potential to limit antibiotic resistance in the post-acute care setting, while improving treatment efficacy and resident safety, and may create a reduction in treatment-related costs.		