

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/30/2026
NAME OF PROVIDER OR SUPPLIER Rushville Nursing & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 135 South Morgan Street Rushville, IL 62681	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review, and interview the facility failed to care plan the level of assistance each resident requires for Activities of Daily Living (ADL). This affects all 68 residents residing at the facility. The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 6/28/26 documents the facility census as 68 residents. The facility's Care Plan Policy dated October 2022 documents an individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and/or psychological needs is developed for each resident. The policy further documents the Comprehensive Care Plan has been designed to reflect the resident's needs and preferences. On 6/29/26 at 9:50 AM V12 (Registered Nurse) reported resident care needs are on the resident's individualized care plan. On 6/29/26 at 11:07 AM V6 (Restorative Nurse) reported V6 is responsible for the ADL (Activities of Daily Living) care plans and V6 only care plans the assistance resident requires for transfers. Bathing, dressing, bed mobility, eating, and mobility are not addressed on the residents' care plans. On 6/30/26 at 8:24 AM V1 (Administrator) confirmed none of the resident care plans address the resident's ADL (Activities of Daily Living) assistance needed with exception to transfers. On 6/30/26 at 11:02 AM V6 (Restorative Nurse) reported there is not a resident in the facility that is independent with all ADL's. V6 reported all residents require supervision or hands on assist with ADL's (Activities of Daily Living).		

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review the facility failed to ensure garbage/refuse container lids are closed. This has the potential to effect all 68 residents. The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 6/28/26 documents the facility census as 68 residents. The facility's undated Garbage Disposal Policy documents Keep dumpster closed at all times. On 6/29/26 at 7:00 AM the dumpster lid was not closed on one of the two dumpsters. V4 (CNA/Certified Nursing Assistant) verified dumpster lids are to be closed at all times and stated, Sometimes we need three of them.		

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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. Based on observation, interview, and record review the facility failed to maintain dignity for two (R5, R7) of two residents reviewed for dignity in a total sample of 68. Findings include: The facility's undated Assisting a Client with Eating Policy documents Sit with the person and assist with the meal as needed. The facility policy, Resident Rights Guideline, revised 10/2023, documents not in its entirety, Our facility will treat each resident with respect and dignity and care for each resident in a manner an in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility protects and promotes the resident of the residents. The right to be treated with respect and dignity. 1. On 6/29/26 at 8:54 AM V7 (CNA) was standing next to R7 feeding R7 breakfast . V7 stated, I'm the only one in here, so I'm going table to table to help the residents. I usually sit when I have help in here. On 6/29/26 at 12:50 PM V2 (Director of Nursing/DON) confirmed staff should be sitting with the resident when assisting residents with feeding. 2. R5's resident face sheet documents R5's date of re-admission to the facility was 3/23/26 and R5's diagnoses include but are not limited to Pressure Ulcer of Sacral Region Stage 4, Type 2 Diabetes Mellitus without complications, and Urinary Tract Infection site not specified-VRE (Vancomycin (Antibiotic)-resistant Enterococci (bacteria). R5's physician orders dated 6/25/26 documents that R5 has a treatment to coccyx of cleanse with wound cleanser, pat dry, apply Fibracol (medicated wound dressing) to wound bed and cover with dry dressing daily and as needed. On 6/29/26 at approximately 9:30am, V9 (Registered Nurse) and V8, V10 (Both Certified Nursing Assistants) observed doing wound care to R5's coccyx wound. V8 and V10 were noted to hold R5 over onto her right side facing the window in her room. R5 was without clothing from her waist down exposing her naked buttocks to the doorway of her room. Privacy curtain was not pulled around R5. V9 opened R5's door to her room to access the treatment cart while R5's naked buttocks were exposed to potential peers and visitors in the hallway outside her room for approximately 1 minute prior to V9 grabbing the treatment cart and pulling it to the doorway at which time V8 noted that R5's buttocks were exposed and covered R5 with a sheet. On 6/29/26 at approximately 10am, V8 and V10 (Both Certified Nursing Assistants) confirmed that the privacy curtain should have been pulled around R5 during cares. On 6/29/26 at approximately 10:30am, V9 (registered Nurse) confirmed that R5's naked buttocks were exposed to the hallway and confirmed that she (V9) should have made sure R5 was covered prior to opening the door.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to attempt any nonpharmacologic intervention prior to using psychotropic medications for three residents (R17, R26, R27) and failed to GDR (Gradual Dose Reduction) for two residents (R17, R27) of 5 residents reviewed for unnecessary medications in total sample of sixty-eight. Findings Include: The facility's Psychotropic Medication policy dated 2/2025 documents Use of Anxiolytic/Sedative drugs for purposes other than sleep induction should only occur when 1. Evidence exists that other possible reasons for the resident's distress have been considered and ruled out. The facility's Psychotropic Medication policy documents Antipsychotic medications in persons with dementia should not be used if one or more of the following is/are the only indication: 1. Wandering 2. Poor self care 3. Restlessness 4. Impaired memory 5. Mild anxiety 6. Sadness or crying alone that is not related to depression or other psychiatric disorders 7. Insomnia 8. Inattention or indifference to surroundings 9. Fidgeting 10. Nervousness 11. Uncooperativeness (e.g. refusal of or difficulty receiving care). All of the above highlighted conditions/diagnosis where antipsychotic medications may be possibly be appropriate, but diagnoses alone do not warrant the use of an antipsychotic unless the following criteria are also met: The behavioral symptoms present a danger to the resident or others. The facility's Psychotropic Medication policy documents Unsuccessful reduction of medication must be substantiated by documentation, including a physician statement why the medication cannot be reduced farther. Clinically contraindicated means that a resident need not undergo a gradual dose reductions or behavior intervention if the resident has a specific condition and has a history of recurrence of psychotic symptoms which have been stabilized with a maintenance dose of an antipsychotic drug without incurring significant side effects. In residents with dementia, clinically contraindicated means that a gradual dose reduction has been attempted twice in one year and that attempt resulted in the return of symptoms for which the drug was prescribed to a degree that a cessation in the gradual dose reduction, or a return to previous dose levels was necessary. The resident's physician provides a justification that includes: a) diagnosis, but not simply a diagnostic label or code, but the description of the symptoms, b) a discussion of the differential psychiatric and medical diagnosis (e.g., why the resident's behavioral symptom is thought to be a result of a dementia with associated psychosis and/or agitated behaviors and not the result of an unrecognized painful medical condition or a psychosocial or environmental stressor) c) a description of the justification for the choice of a particular treatment, or treatments, and d) a discussion of why the present dose is necessary to manage the symptoms of the resident. This information need not necessarily be in the physician's progress notes, but must be a part of the resident's clinical record. Documentation confirming that previous attempts at dosage reduction have been unsuccessful. 1. R27's Medical Record documents that she was admitted on [DATE] with diagnosis to include but (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not limited to Unspecified Dementia with behavioral disturbance, Type II Diabetes Mellitus and Repeated Falls. R27's Medical Record documents that she is rarely/never understood. Throughout the survey R27 propelled self up and down hallways, into walls, into other residents. R27 did not speak when spoken to and did not acknowledge speaker. R27 appeared calm and confused. R27's Physician Order Sheet for April 2026 documents that she received Seroquel (Antipsychotic Medication) 25 mg (milligrams) for Dementia every night. R27's Pharmacy Recommendation accepting a Gradual Dose Reduction of the Seroquel to 12.5 mg every night was signed by V21 (R26's Doctor) was dated 4/2/26. R27's Behavior Monitoring Logs for April and May contain documentation of refusal of cares for 21 instances over the two months. No other behaviors were being monitored. R27's Physician Order Sheet documents a new order from V21 (R26's Doctor) on 5/18/2026 for Hydroxyzine (An antihistamine used primarily to treat anxiety, allergic skin reactions and itching. It works as a non-addictive sedative to calm the central nervous system) for Dementia. On 6/30/26 at 10:00 AM V18 (Registered Nurse/Psychotropic Nurse) stated that R27 is on an Antipsychotic medication for Dementia and anxiety. V18 stated that when she spoke with V21 (R27's Doctor) the plan was to use the Hydroxyzine to manage R27's anxiety and to get her off the Antipsychotic. This plan was not documented anywhere in R27's Medical Record. R27's Medication Record documents that R27 received Hydroxyzine 50 mg once on 5/19/2026. R27's Progress Notes dated 5/25/26 document that V21 (R26's Doctor) considered the GDR failed and returned her to the previous dose of Seroquel 50 mg every night. R27's Medication Record documents that R27 currently receives both the Seroquel 50 mg every night and Hydroxyzine 50 mg every 6 hours as needed. On 6/30/26 at 11:00 AM V5 (Social Services Director) stated that she did not believe any of R27's behaviors were harmful. V5 stated anxious? Yes, very. But she doesn't hurt anyone or herself. V5 stated that the Identified Behavior that V5 (SSD) decided to track for R27 was refusal of cares/combativeness with cares. V5 (SSD) stated A lot of residents with dementia don't like showers or changing their clothes. R27's current care plan does not contain any personalized interventions for R26 for any behavior issues. R27's care plan documents (R27) takes antianxiety medication. Approach: Implement a behavior management plan. 2. R26's Medical Record documents that he was admitted on [DATE] with diagnosis to include but not limited to Anxiety, Osteomyelitis and Type 2 Diabetes Mellitus. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R26's Physician Order Sheet documents he was admitted on Ativan 1 mg twice daily as needed for anxiety. This as needed prescription did not have an end date. R26's Medication Administration Record documents that R26 takes his as needed Ativan almost daily for the month of June. On 6/28/26 at 1:00 PM R26 stated that he started the anxiety pill while hospitalized for osteomyelitis . My whole situation with maybe losing toes and having to be here (at facility) just makes me anxious. I get in my own head about things and over think them. R26 stated that he didn't know if counseling would help, but stated he would be open to other ways to manage his anxiety. No one has really offered anything else other than the pill. R26's Behavior Monitoring Logs for June documented zero instances of anxiety by R26. R26's Medication Administration Record documents that R26 received the Ativan 1 mg every day in June, sometimes twice a day. The reasoning for these medication administration ranged from pain other and behavior issue. R26's Progress Notes or Behavior Monitoring Logs do not contain any documentation of any nonpharmacologic interventions attempted prior to the administration of the Ativan. R26's current care plan documents (R26) takes anxiety medication Implement a behavior management program. Attempt non pharmacological interventions. On 6/30/26 at 9:30 AM V18 (Registered Nurse/Psychotropic Nurse/Care Plans) stated I don't do those (behavior management care plans) (V5/SSD) should be doing those. On 6/30/26 at 11:00 AM V5 (SSD) stated she has never done any kind of behavior management plan for any of the residents. V5 did confirm there were no personalized interventions on R26 and R27 current care plans. V5 also confirmed that both care plans stated attempt nonpharmacologic interventions and did not list what worked for this resident or what was available at this facility to attempt to manage behaviors/anxiety. 3. R17's Medical Record documents that he was readmitted on [DATE] with diagnosis to include but not limited to Schizoaffective Disorder Bipolar Type, Dementia in other diseases classified elsewhere unspecified severity with other behavioral disturbances, Major Depressive Disorder, Generalized Anxiety Disorder and Chronic Obstructive Pulmonary Disease. R17's Physician Order Sheet documents he has an order for Olanzapine (antipsychotic) 5mg (milligrams) every 6 hours as needed for agitation. This as needed prescription did not have an end date. R17's Behavior Monitoring Logs for June documented one instance of agitation by R17 on 6/1/26. R17's Medication Administration Record documents that R17 received the Olanzapine (antipsychotic) (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5 mg (milligram) on 6/4/26 one time with no documented agitated behavior. R17's Progress Notes or Behavior Monitoring Logs do not contain any documentation of any nonpharmacologic interventions attempted prior to the administration of the Olanzapine (antipsychotic). R17's current care plan documents (R17) currently receiving antipsychotic and anticonvulsant medications Implement a mood management plan to complement drug therapy. Quantitatively and objectively document behavior/mood. On 6/30/26 at 11:10 AM V5 (Social Service Director) stated she has never done a behavior management plan for any of the residents. V5 did confirm there were no personalized interventions on R17's current care plan. V5 also confirmed that care plan stated, Quantitatively and objectively document behavior/mood and stated, I've always been told if it's not documented then it did not happen. V5 confirmed there was no documentation in R17's medical record indicating behaviors had occurred for the month of June except the one occurrence documented on behavior log for 6/1/26.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide documentation of communication with the dialysis facility for three residents (R1, R2, R42), failed to have appropriate physician orders for two residents (R1, R42), and failed to implement a care plan for one resident (R1) of three residents reviewed for dialysis in a sample of 68. Findings include: The facility policy, Hemodialysis Guidelines, dated 4/3/24, documents, Care interventions required when a resident is on hemodialysis may exceed the usual identified problems and interventions provided to residents in long-term care setting. The following information will provide additional direction in assessment, planning and provision of care to our residents. Residents receiving hemodialysis are transported routinely out of the facility. Communication is essential for continuity of care. Education surrounding the care of the unique needs of the resident on hemodialysis is also important. Communication between outpatient dialysis provider and facility should include written communication form with review of daily weights, any changes in condition or mood. Pre-Dialysis Protocol: Be cognizant of medications ordered and timing of administration. Be aware of any meals that may be missed and arrange for routine boxed lunches to be provided by dietary. Observe for lethargy, chest pain, headache, unsteady gait or nausea. Communicate symptoms to outpatient dialysis center and physician. Communicate/facilitate plan for preventative skin interventions. Post Dialysis Protocol: Review Communication Folder for any pertinent information. Remove fistula/graft-dressing evening of dialysis treatment and/ or as directed by the nephrologist. Check fistula for bruit (listening to fistula) or feel for a thrill (by touching the fistula.) This must be done daily, best after dressing is removed. If bleeding occurs any time after dialysis, apply pressure with clean gauze for 5-10 minutes. Repeat until the bleeding stops or call the dialysis unit (if open) or M.D. for further instructions. Blood pressure pm/daily or as the physician orders (do not take B/P on arm that fistula is in). Normal activity as tolerated. Observe skin/heels for any pressure areas from extended sitting/lying during dialysis. Emergency Protocol: Fistula/ Graft Daily Fistula/Graft Checks: Check for any signs of infection daily, these may appear as: redness, hardness, swelling, pain, drainage, and elevated temperature and body chills. Call the physician promptly. If bleeding occurs at needle sites any time after dialysis, apply pressure with clean gauze for 5-10 minutes. Repeat until bleeding stops. If this intervention does not control the bleeding a physician should be notified. Documentation on Treatment Sheets Includes: Fistula checks daily: Monitoring for presence of bruit and thrill. Checks for signs/symptoms of infection daily. Care of the Fistula/Graft: Residents should avoid lying or sleeping on the access arm. Avoid any tight clothing on the access arm. This may restrict the blood flow to access and increase the risk of clotting. Residents should avoid carrying a purse or heavy items on that arm. Avoid wearing a watch or bracelets on the access arm. No blood pressure is to be taken on the access arm. No blood is to be drawn from that arm or intravenous access to be placed in the access arm unless ordered by Dialysis Unit or resident's Physician. Keep dressings over exit sites clean, dry and in place. Emergency Protocol External Catheters: External Catheters-Avoid scissors or sharp objects around the catheter. Remind the resident not to pinch, poke, bend or pull at the catheter. Always have a smooth clamp at the bedside for use in emergency situations. Clamps should remain clamped and end caps should be tight on any temporary external catheter. Avoid getting these types of catheters wet while bathing. You may cover site with saran wrap or plastic covering during baths. If dressing becomes wet, falls off or pulled off by resident, you (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will need to replace the dressing. Cleanse the area in a circular motion using Betadine swabs or Hibiclens. Allow the area to dry and cover with a sterile gauze or Tegaderm type dressing. Use sterile technique with this dressing change. Make a note to the Dialysis Unit in the resident's folder that they bring to dialysis. If a catheter is accidentally cut or torn, immediately clamp the catheter near the exit site with a smooth clamp, you may also bend the catheter over and tape it tightly Assess the resident for signs of an air embolism, sob, chest pain or respiratory embolism, position resident on left side with head down and feet up- call 911. If catheter is pulled out, immediately apply pressure in the general area of the junction of the medial end of the clavicle and the sternomastoid muscle (internal jugulate vein). Applying pressure for 15-20 minutes will usually stop any bleeding. Check the catheter to be sure it is intact if not apply sterile gauze to exit site then notify M.D. at dialysis or primary physician if dialysis closed. 1. R1's Physicians Orders dated 6/1/26 by V21 R1's Physician includes the following order: Dialysis: Hemodialysis (local Dialysis Unit) in Rushville. Once a Day on Mon, Wed, Fri; Days; Dialysis: Check access site _____ for redness, bleeding and swelling. If any bleeding or oozing from site APPLY PRESSURE GAUZE DRESSING & NOTIFY PHYSICIAN. (Instructions for entering dialysis orders included in this order state the following: Special Instructions: enter the site above and select the correct dialysis days and delete this.) R1's Physicians Orders do not identify the R1's dialysis access site location or type of dialysis access utilized for hemodialysis. R1's dialysis access site was not identified or documented in Physicians Orders, Care Plan or Nursing Progress Notes. Additionally, there were no orders or parameters regarding laboratory monitoring for R1's dialysis treatments. On 6/30/26 at 9:55am, R1 indicated his dialysis access was a fistula, indicating a dressing which was in place on his left upper arm. 2. R3's EHR (Electronic Health Record) documents R3 was admitted to the facility on [DATE] with diagnoses to include End Stage Renal Disease, Chronic Obstructive Pulmonary Disease, Gout, Anemia, Diabetes Mellitus, Hypertension, and Atrial Fibrillation. R3's Care Plan documents R3 receives hemodialysis twice a week at the dialysis center. The most recent dialysis communication form in R3's Electronic Health Record is dated 6/30/25. 3. R42's resident face sheet documents R42's date of admission to the facility was 2/11/25 and R42's diagnoses include but not limited to End Stage Renal Disease, Type 2 Diabetes Mellitus with Diabetic chronic Kidney Disease, Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, Essential Hypertension, and Chronic Systolic Congestive Heart failure. R42's physician orders dated 6/4/25 documents R42 has orders for Hemodialysis external to facility on Monday, Wednesday, and Friday days. R42's physician orders do not specify individualized dialysis prescriptions such as the length of treatment time, type of dialyzer, specific parameters of the dialysis delivery system [electrolyte composition of the dialysate, blood flow rate, and dialysate flow rate], anticoagulation or target weight. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R42's dialysis communication forms dated 1/2/26, 4/8/26, 4/10/26, 4/15/26, 4/22/26, 5/25/26, 6/3/26, and 6/10/26 lack documentation by the facility prior to dialysis treatments. On 6/29/26 at 10:40am, V12 (Registered Nurse) stated that on dialysis days the resident's nurse is to send a dialysis communication sheet with the resident when they go to dialysis but was unsure if they are to fill out the top portion of the form. V12 stated, I know we have orders to do his (R42) blood pressure on off days but I am not sure if we are to be doing vital signs (blood pressure, temperature, respirations, pulse and weight) prior to him going to dialysis. He goes every Monday, Wednesday and Friday early in the morning before my shift. V12 also verified that R42's physician orders did not specify where R42 goes to dialysis, dialysis prescription, anticoagulation, or target weight. On 6/29/26 at 1:17pm, V2 (Director of Nursing) stated she has never seen the location of dialysis on the physician orders because they only have one location that the dialysis residents use and thought they only need what type of dialysis resident was receiving and the days of treatment on the orders. V2 also confirmed that the nurses are to fill in the top portion of the dialysis communication sheets prior to residents going to dialysis and the dialysis center is to fill in the bottom portions and return to the facility. On 6/30/26 at 7:40 AM V13 (Registered Nurse) reported the dialysis communication form does not return with the residents who go to the dialysis center. On 6/30/26 at approximately 10:40am V18 Care Plan Coordinator verified there was no documentation of R1's dialysis access site present in R1's current medical record, Care Plan or Physicians Orders. On 6/30/26 at approximately 10:45 am, V15 Transporter/Medical Records stated the Dialysis Communication Form has an area for the facility Nurses to fill out prior to the resident's transfer to the dialysis unit and an area designated for the dialysis unit staff to complete after the resident's dialysis treatment is completed and prior to transport back to the facility. V15 stated the lack of completed Dialysis communications Forms has been an ongoing issue. The facility was unable to provide completed Dialysis Communication Forms for R1, R3, and R42 documenting vital signs, weight and condition information by facility Nursing staff upon transportation to the local dialysis unit, nor the documentation by the dialysis unit staff for the facility Nursing staff, identifying the resident's condition and vital signs upon completion of the dialysis treatments.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review the facility failed to ensure staff utilized appropriate PPE/Personal Protective Equipment during mechanical lift transfer of one resident (R5) on Enhanced Barrier Precautions and failed to post Enhanced Barrier Precautions alert signage for one (R47) of 24 residents reviewed for Infection Control in the total sample of 68. The facility's Enhanced Barrier Precautions policy, dated 03/21/24 documents the following: It is the practice of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug resistant organisms (MDRO). Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for .residents with wounds or indwelling medical devices. Initiation of Enhanced Barrier Precautions &ndash; b. Implement enhanced barrier precautions for residents with any of the following: wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices.even if the resident is not known to be infected or colonized with a MDRO. High=contact resident activities include: c. Transferring; h. Wound care: any skin opening requiring a dressing. 1. R47 is a [AGE] year-old resident with diagnoses including: Lymphedema; Colostomy and Bilateral Lower Extremity (BLE) Venous Ulcers. R47's current Open-Ended Physicians Order by V21 documents: Enhanced Barrier Precautions related to Ostomy. R47's medical record included the following Open-Ended treatment orders by V14 NP/Nurse Practitioner & Wound Specialist: Colostomy: Empty bag. As Needed and Perform care Every Shift; Days, Nights, as well as extensive wound treatments and dressing change orders dated 6/18/26, by V14, for Left and Right Lower Extremity open wounds. R47's current Care Plan documents the following: Problem Start Date: 06/07/26: (R47) admitted to facility with venous ulcers to her BLE (Bilateral Lower Extremities). as well as the Problem: (R47) requires Enhanced Barrier Precautions d/t (due to) colostomy and open wound. On 6/28/26 at 10:00am no EBP signage was posted on or near R47's room door to alert staff and visitors to the need for PPE/Personal Protective Equipment during high-contact activities. On 6/29/26 at approximately 9:35am, V9 Wound Nurse stated R47 receives extensive daily treatments and dressing changes for multiple open ulcers on both lower legs. On 6/29/26 at 11:00am R47 was seated in her room with dressing wraps in place to both of her lower legs. Obvious drainage was present through both dressing wraps. R47 stated nursing staff change her (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/30/2026
NAME OF PROVIDER OR SUPPLIER Rushville Nursing & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 135 South Morgan Street Rushville, IL 62681	
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 - Few	dressings daily. There was no signage identifying the need for Enhanced Barrier Precautions present on or around R47's door. On 6/29/26 at approximately 11:25am, V9 removed the soiled dressing wraps from R47's legs exposing multiple open wounds present on R47's lower legs. On 6/30/26 at approximately 10:0am V3 Infection Preventionist verified there was still no EBP alert signage present on R47's door area and R47 should have EBP signage posted on or near the door in order to alert staff and visitors to the need for specific PPE for high-contact activities. 2. R5's resident face sheet documents R5's date of re-admission to the facility was 3/23/26 and R5's diagnoses include but are not limited to Pressure Ulcer of Sacral Region Stage 4, Type 2 Diabetes Mellitus without complications, and Urinary Tract Infection site not specified-VRE (Vancomycin (Antibiotic)-resistant Enterococci (bacteria).) R5's physician orders dated 3/23/26 documents R5 has an order for Enhanced Barrier Precautions, and strict isolation due to positive wound culture. R5's physician orders also document that R5 has an indwelling urinary catheter and treatment for coccyx wound to be completed daily and as needed. R5's current care plan documents that R5 has an indwelling urinary catheter, stage 4 (four) pressure ulcer to her coccyx and requires Enhanced Barrier Precautions due to indwelling medical device, open wound with intervention to wear gown and gloves when performing high-contact resident activities and transfers via sit to stand lift. On 6/29/26 at approximately 10:00am V8 and V10 (Both Certified Nursing Assistants) observed getting ready to transfer R5 per sit-to-stand mechanical lift. V8 observed placing mechanical lift sling around R5's upper torso wearing only gloves. On 6/29/26 at approximately 10:15am V8 confirmed she should have been wearing a gown and gloves when placing mechanical lift sling around R5 since it was a high contact activity.		