

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145500	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/08/2025
NAME OF PROVIDER OR SUPPLIER  Hillsboro Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE  1300 East Tremont Street Hillsboro, IL 62049	

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 0686  Level of Harm - Actual harm  Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing.  (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0686  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to implement end of life/hospice skin care plan interventions for 1 of 3 (R2) residents reviewed for pressure ulcers in the sample of 5. This failure resulted in R2 developing multiple in-house acquired pressure ulcers between the dates of [DATE] and [DATE] when R2 expired at the facility. Findings include:R2's admission Record, print date of [DATE], documented R2 had diagnoses including dementia, COPD (chronic obstructive pulmonary disease), severe protein calorie malnutrition, thrombocytopenia, pressure ulcer of left heel, anxiety disorder, chronic atrial fibrillation, congestive heart failure, type 2 diabetes mellitus, osteoarthritis, and chronic kidney disease. R2's MDS (Minimum Data Set), dated [DATE], documented R2 was severely cognitively impaired and was dependent on staff for all mobility including bed mobility. R2's Pressure Score Risk document, dated [DATE], documented R2 was assessed as very high risk for skin breakdown. R2's Nursing Admission/readmission Data Collection document, dated [DATE], documented R2 was re-admitted to the facility following a local hospital admission with a pressure ulcer to his sacrum. This form documented R2's pressure ulcer of his sacrum was 1.1 cm in length and 1.0 cm in width with no depth documented. This form also documented R2's right heel had an old, healed blister and R2 had abrasions to his right antecubital. No other skin impairments were documented. R2's progress noted, dated [DATE] at 5:00 PM, documented R2 was admitted to (regional) hospice services on the same day he was re-admitted to the facility from a local hospital. R2's Hospice Certification and Plan of Care, dated [DATE], documented wound care to buttock and left heel every 3-5 days and PRN (as needed) for drainage; clean with wound cleanser; pat dry; apply skin prep; cover and secure with Mepilex dressing. Wound care to be performed by facility nurse. It continues, DME (durable medical equipment) and Supplies: alternating pressure pad. R2's care plan report, undated, documented R2 has actual/potential impairment to skin integrity r/t impaired mobility, incontinence, diabetes mellitus, poor appetite, CHF (congestive heart failure), COPD, anemia, EOL (end of life) process and his disease process. admitted with stage 2's to sacrum/coccyx, scarring to left heel r/t old, blistered area. DTPI (deep tissue pressure injury) right heel, several DTPI to bilateral torso/sides and back and left shoulder and right lateral leg, skin tears to right side. Interventions include Monitor dressing when providing care to ensure it is intact and adhering, report loose dressing to nurse. Monitor pressure areas for changes in color, sensation, temperature and report any change to nurse. Pressure redistributing mattress on bed. R2's progress note, dated [DATE] at 7:00 PM, documented, hospice nurse here to see resident. During care she asked CNA (Certified Nurse Assistant) why low air loss mattress isn't on bed CNA hospice nurse asked writer why and stated the CNA said, because the DON (Director of Nursing) doesn't like them. The writer explained I didn't know about it but perhaps she could talk to the DON tomorrow I'm sure there is a misunderstanding. Resident noted per hospice nurse to have several new wounds back, bilat torso, left shoulder, right elbow, buttock, right knee, and left heel. Daughter informed family and new treatment orders given.On [DATE] at 9:40 AM, V6, CNA, stated the air mattress hospice brought in for R2 was never put on his bed and she doesn't know why. V6 stated hospice picked the mattress up last week after R2 passed away.On [DATE] at 10:20 AM, V2, DON, stated she is a traveling DON, started at this facility approximately 3 weeks ago. Hospice ordered an overlay for R2. V2 stated, We decided those aren't safe, so we ordered an air mattress from hospice, and it didn't come until (R2) had already expired. V2 stated R2 had multiple pressure ulcers. V2 stated on [DATE], R2 had tiny areas on his coccyx, on the 22nd it appeared as a Kennedy ulcer and the Nurse Practitioner came and looked at it, and then diagnosed it as a Kennedy ulcer.On [DATE] at 10:25 AM, V10, RN (Registered Nurse), stated R2's pressure ulcers gradually got worse after he was re-admitted on [DATE]. V10 stated when R2 was re-admitted to the facility on [DATE], she completed R2's admission assessment including his skin assessment. V10 stated she observed an approximate nickel sized open area to R2's sacrum on [DATE]. V10 stated towards the end of R2's stay at the facility, he started developing more wounds. V10 stated R2's hospice company delivered an overlay for his mattress, but it didn't follow protocol, so it was never placed on his bed. V10 stated she is not sure who made the decision not to use the overlay. On [DATE] at 10:43 AM, V2, DON, was asked if the facility assessed, measured, and monitored R2's pressure ulcer on his sacrum between [DATE] when it was noted on his re-admission assessment as 1.1 cm in length x 1 cm depth until [DATE] when the next measurement of 2.36 cm length x 3.57 cm width x .2 cm depth. V2 replied, I can't tell you anything, unfortunately. We did have a wound care nurse, but she quit. Survivor</p>		