

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: 145500	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to prevent abuse for 3 of 3 residents (R1, R12, and R17) reviewed for abuse in the sample of 17. This past non-compliance occurred from 5/3/2026-5/5/2026. Findings include; 1. The facility State report dated 5/4/2026 final report documents date and location of incident 5/4/2026 in dining room. The report documents brief description of incident: On 5/4/2026 staff witnessed a resident-to-resident interaction between R17, R10 and R1. The report documents type of injuries: none. The report document R1, R17 and R10 were interviewed, statements as follows: R1 was interviewed and did not recall anything happening. R17 denied the allegation. R10 was interviewed and stated, What are you talking about? I did not do anything wrong, I just kissed my wife. The report documents staff walked out of resident room from doing a bed check and observed R10 kissing R1. The report documents staff separated R1 and R10 and redirected to his room. The report documents staff went to the administrator's office to inform of the event she witnessed. The state report documents V21, Certified Nursing Assistant/CNA stated, I observed (R10) coming in the dining area and touched (R17's) hand and started to kiss (R17). The report documents R10 kissed R17 before staff could separate them. R10's undated face sheet documents a diagnosis in part of encephalopathy, hypertensive heart disease with heart failure, cognitive communication deficit R10's care plan, dated 11/17/2025, documents R10 has impaired cognitive function/dementia, Care plan, dated 4/24/2026, documents R10 has confusional episode with interventions dated 4/24/2026 has difficulty with remembering where he is room or bathroom is needs verbally cueing to find the rooms. R10's care plan, dated revised 5/7/2026, documents R10 has a behavioral problem the following interventions, dated 5/4, document R10 sent to hospital for evaluation and treatment. R10's care plan documents behavior #5 R10 mistakes females to be his wife redirect, separate resident; assist resident to sit with males R10's Minimum Data Set (MDS), dated [DATE], documents a Behavioral Interview of Mental Status (BIMS) of 3, indicating cognitive impairment. R1's current undated face sheet documents a diagnosis in part of: Alzheimer's Disease unspecified, heart failure, dementia in other diseases classified elsewhere, moderate without behavioral disturbance, Psychotic disturbance, mood disturbance and anxiety, cerebrovascular disease unspecified, Atherosclerotic heart disease, angina pectoris R1's Minimum Data Set (MDS), dated [DATE], documents unable to score Behavioral Interview of Mental Status (BIMS) R1's Care Plan, dated 7/28/2025, documents R1 has been identified as being a vulnerable person related to her diagnosis of dementia. R1's care plan documents intervention dated 7/28/2025 frequent rounding by staff to maintain safety and ensure resident needs are met. R1's Care Plan, dated 10/15/2025, documents R1 has impaired cognitive function/dementia or impaired thought processes Alzheimer's disease, Dementia, Impaired decision making. R1's care plan documents R1 has an Activity Daily (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Living (ADL) self-care performance deficit dementia. R1's care plan documents R1 requires staff assistance time 1 for bathing, bed mobility, dressing, standby supervision for ambulation, personal hygiene, transfers and toileting. R17's undated face sheet documents diagnosis in part of unspecified Dementia, traumatic subdural hemorrhage without loss of consciousness and anxiety disorder R17's Care plan documents R17 has been identified as being a vulnerable person related to dementia R17's care plan documents the following interventions; frequent rounding by staff provided to maintain safety and ensure resident needs are met, resident resides on a closely supervised unit, social services will follow closely as need after each incident, trauma assessment will be completed for each incident. R17's Care plan documents has and ADL self-care deficit and R17 has unsteady balance and unsteady gait, requires staff assistance x1 for bathing bed mobility, dressing, personal hygiene, toileting and transfers. R17's MDS, dated [DATE], documents a BIMS of 4 indicating cognitive impairment. 2. The facility State Report, dated 5/3/2026, documents brief description of incident; resident to resident altercation, no injury noted. The report documents R12 entered R8's room and started talking to the staff. The report documents R8 walked into room and yelled 'don't touch my purse.' R8 then pushed R12. R12 fell into staff. The staff and R12 both landed on bed. R8's undated face sheet documents a diagnosis in part of major depressive disorder, recurrent, severe with psychotic symptoms, unspecified dementia, and bipolar disorder. R8's MDS, dated [DATE], documents a BIMS of indicating R8 is cognitively intact. R8's Care plan, dated 4/30/2026, documents R8 has a behavior problem related to anxiety with behaviors identified, or attention seeking behaviors, sadness, aggression toward others and more frequent allegations. R12's undated face sheet documents in part a diagnosis of bipolar disorder, Alzheimer's disease, and cognitive communication deficit. R12's MDS, dated [DATE], documents R12 is severely cognitively impaired with a BIMS of 3. R12's care plan, dated 4/13/2026, documents R12 has impaired cognitive function related to dementia. On 7/23/2026 at 8:56AM, V1, Administrator, stated she would expect the facility to follow the abuse policy. The facility ABUSE, PREVENTION AND PROHIBITION POLICY, dated 11/25, documents each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The policy documents the facility prohibits mistreatment, neglect, or abuse of residents. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that all instances of abuse, even those residents in a coma, can cause physical harm, pain, or mental anguish. The residents must not be subjected to abuse by anyone. The policy documents the resident has the right to be free from verbal, mental, sexual, exploitation, or physical abuse; corporal punishment and involuntary seclusion. Prior to the survey date of 7/20/2026, the Facility took the following steps to correct the non-compliance: 1. staff education regarding the abuse policy, with emphasis on separating residents involved and initiating supervision to avoid further concerns. 2. Monitoring for compliance; the administrator and/or designee will conduct 5 audits weekly for 60 days regarding the abuse policy, with emphasis on separating resident involved and initiating supervision to avoid further concerns. Monitoring for compliance: The administrator and/or designee will conduct 5 audits weekly for 60 days to avoid further concerns, The DON and/or designee will review documentation during the QA clinical meeting regarding change in conditions and/or behaviors. any concerns will be addressed immediately during the QAPI. The facility documents dated of compliance as 5/5/2026. The facility in-service record dated 5/5/2026 documents all staff re-trained. Records document audits were completed as ordered. The Facility's Past-Noncompliance was confirmed (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	through interviews with V1,V22, V23. and V24. Review of in-service sign in sheets, and review of all Facility audits.		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent theft from occurring for 2 of 3 residents (R4, R5); reviewed for Misappropriation in a sample of 17. This Past Non-Compliance occurred from 6/15/26 through 6/25/26. Findings include: 1. R4's Facesheet, with a print date of 7/20/26, documented he was admitted to the facility on [DATE] with diagnosis of, in part, Alzheimer's disease, heart failure, and cirrhosis of the liver. R4's Minimum Data Set (MDS), dated [DATE], documented he was cognitively intact. R4's Care Plan, dated 5/27/25, documented he had impaired cognitive function/dementia or impaired thought processes dementia with an intervention added on 6/20/26 that he was offered a lock box for cards and money and educated on resident trust account. R4's Bank Letter, dated 7/6/26, documented, Based on the facts of the investigation for transaction(s) listed immediately below, it was determined that the claims are valid. As of July 6, 2026, the claims listed in the table directly below are considered closed and the provisional credit you received in the amount of \$44.68 is permanently credited to your account. (R4) was interviewed and stated, I can't find my debit card. I thought I had it at the snack machine yesterday. Room search complete with resident approval and unable to locate card. Guardian was notified and activity checked on the card. There were two unauthorized transactions noted on his card. Smoke shop for \$30.44 and ice cream shop in surrounding town \$14.24. Guardian had the card put on hold. It is believed V26 (CNA/certified nursing assistant) took R4's card and made purchases. On 7/20/26 at 9:38 AM, R4 stated he had an issue a while back with one of his cards and the facility took it from him as requested by his son to do. R4 stated his son told him that there were two unauthorized charges made on the card and had the card canceled but does not know what happened after that; his son has full control over all his finances and care. 2. R5's Facesheet, with a print date of 6/16/26, documented she was admitted to the facility on [DATE] with diagnosis of, in part, chronic respiratory failure, type two diabetes mellitus, and hypertension. R5's Care Plan, dated 5/30/25, documented she had a potential for psychosocial well-being problem with interventions of, in part, educating her on resident trust accounts and encouragement to use lock box for personal belongings and items dated 6/23/26. R5's State Report, dated 6/16/26, documented she was cognitively intact. R5's State Report continued to document the police were able to contact businesses and obtain security footage that revealed V26 using R5's debit card to make purchases. It was believed that the same staff member took the R5's cash as well. The police spoke to V26 regarding the allegations, and he admitted to taking the card and money. V26 had worked at the facility for only one day and on one hall. On 7/20/26 at 10:01 AM, R5 stated one of her cards got stolen a while back. R5 stated she reported it missing to one of the CNAs and they immediately started investigating. R5 stated a cop came in and followed up on everything and mentioned they think an agency CNA was responsible for it. R5 stated she's pretty sure charges were made. R5 stated V10 (SSD/Social Services Director) was very helpful, including V1 (Administrator) in following up on everything and tracking the charges. R5 stated they did end up finding a few different charges that were unauthorized, and we contacted the bank to have it canceled. R5 stated, The facility paid me back. On 7/23/26 at 1:40 PM, V10 (Social Services Director/SSD) stated she was notified R5's money and card were missing so she immediately started working with V1, V2, and V18 on figuring out what had happened. V25 stated they reported to the police everything they found. V25 stated they were able to pretty much figure out who would have been the likely person responsible by going through the schedule and location of the charges being placed to the agency CNA who had worked on R5 and R4's hall. V25 stated the money was refunded to (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	both R4 and R5 she believes. V25 stated now they provide lock boxes for all the residents and have not had any further concerns. On 7/23/26 at 1:46 PM, V18 (Assistant Director of Nursing/ADON) stated when she came in they had already been looking into R4's theft. V18 stated she started looking at the schedule and looked up where the agency CNA was from, then correlated the location of the transactions to him. V18 stated they reported all their findings to law enforcement and were able to track the person down pretty fast. V18 stated the money was reimbursed to her knowledge. V18 stated now they have lock boxes for the residents and spoke with all of them as an extra safety measure and have had no concerns since. On 7/22/26 at 2:20 PM, V1 stated she expects staff to do what is right (referring to abuse). V1 stated they banned the CNA from all the facility's buildings. V1 stated, We have started offering lock boxes and safe access for all new admissions and to all the residents now. V1 stated she did in-serving on the abuse policy. V1 stated they have had no further concerns with theft. The facility's Abuse, Prevention and Prohibition Policy, dated 11/2025, documented the facility prohibits misappropriation of resident property. Prior to the survey date of 7/20/26, the facility took the following steps to correct the non-compliance: IMMEDIATE ACTION TAKEN: Social Service and Administrator notified immediately. Called the banks to see if the card had been used. Police Department was notified of the incident. Investigation initiated Both cards are cancelled and will be reissued by the bank. Both residents offered a lock box for their cards and/cash. Administrator completed education with staff on misappropriation of funds (abuse). An AD HOC was completed. The medical director was made aware. V26 was made a do not return from the facility and shift key notified of the incident. Staff were educated regarding the abuse policy with the focus on misappropriation of resident property. All residents with cards/ or cash offered a lock box and educated on resident trust funds. The administrator or designee to be conducting weekly audits for 30 days to ensure the residents' cards are kept secure. The Facility's Past-Noncompliance was confirmed through interviews with V1, V2, V10 and V18, review of in-service sign in sheets, and review of all facility audits.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to provide timely and accurate wound care for 2 of 3 residents (R6, R11); reviewed for quality of care in a sample of 17. Findings include:1. R6's Facesheet, with a print date of 7/22/26, documented he was admitted to the facility on [DATE] with diagnosis of in part, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia following unspecified cerebrovascular disease, and type two diabetes mellitus with other circulatory complications and foot ulcer. R6's Minimum Data Set (MDS), dated [DATE], documented he was moderately cognitively impaired.R6's Care Plan, revised on 7/16/26, documented he had an actual impairment to skin integrity with interventions of, in part, to complete treatments as ordered by physician, dated 5/13/26, keep cushion at end of bed to keep feet off of foot board, dated 5/13/26, wear heel protectors on both feet at all times as tolerated, dated 4/8/26.R6's Skin and Wound note, dated 3/4/26, documented left plantar surface wound larger and appears to have more moisture. The note continued to document V12 (Wound Nurse Practitioner/NP) recommended a wound culture of R6's left plantar foot wound.R6's Skin and Wound note, dated 3/11/26, documented V12 was awaiting culture of left plantar surface wound.R6's Skin and wound note, dated 3/18/26, documented V12 made recommendations to pad his foot board so he is not getting pressure on the bottom of his foot while in bed. The note continued to document V12 was still awaiting orders from PCP (primary care provider) for culture.R6's Skin and Wound note, dated 3/25/26, documented his culture will be obtained today and that R6 needs his footboard padded.R6's Skin and Wound note, dated 4/3/26, documented his left foot wound had ESBL (extended spectrum beta lactamase) and was on Bactrim. The note continued to document R6's footboard was padded now.R6's L Foot (left foot) Culture Results, dated 3/30/26, documented a collection date of 3/26/26 and a resulted date of 3/29/26 with confirmation the wound was positive for E. Coli ESBL (Escherichia coli Extended Spectrum Beta Lactamase) and Staphylococcus (staph) Aureus.R6's Active Orders, with a start date of 7/11/26, documented cleanse open area to right lateral foot with wound cleanser, apply collagen powder and calcium alginate with silver and cover with border gauze dressing daily and PRN (as needed).On 7/20/26 at 2:30 PM, R6's right lateral foot wound care was completed by V8 (wound nurse). V8 cleansed R6's right lateral foot wound with wound cleanser and dressed it with calcium alginate with silver and bordered gauze but did not apply collagen power. V8 stated she is not sure if R6 has any infections because hospice does not continue to test. R6's feet were pressed up against the foot board with no padding. V8 stated, That is the long bed hospice got for R6, they had one for him with padded cushion on the foot board for him, but the padding wouldn't fit with the hospice bed. V8 stated they added the cushion shortly after R6 developed the wounds on his feet. V8 stated R6's foot wounds have been deemed arterial from diabetes.On 7/22/26 at 11:35 AM, V8 (wound nurse) stated R6's wound care orders must have been changed and she didn't notice he was supposed to get collagen powder also. V8 stated wound care is expected to be completed as ordered.On 7/22/26 at 9:34 AM, V12 (Wound NP/nurse practitioner) stated she had recommended a culture of R6's wound back in March because she had concerns it was infected. V12 stated a culture is important to obtain to treat infection with the correct antibiotic. V12 stated the culture was not obtained until 3/25/26. V12 stated she does not know when R6 started antibiotics but on her 4/3/26 appointment he was on Bactrim. V12 stated she does not make orders for the facility, she only makes recommendations, and the PCP (primary care provider) has to put orders in place. V12 stated there was a delay in obtaining R6's culture which had the potential to let the infection worsen and spread to other tissue and bone. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V12 stated R6's culture showed E.coli ESBL and that does not originate in the wound that she is aware of. V12 stated she never confirmed the x-ray results ordered to rule out osteomyelitis of R6's wound herself but confirmed with V8 (wound LPN) there was no osteomyelitis found. V12 stated if her recommendations are not being followed, she could take her concerns to the DON (Director of Nursing) but did not. V12 stated R6 was a tall guy, and she noticed his feet pressed up against the foot board of his bed she was concerned with and recommended cushion to be placed on it. V12 stated she would expect her recommendations to be completed within a week with concerns for his wounds.2. R11's Facesheet, with a print date of 7/22/26, documented she was admitted to the facility on [DATE] with diagnosis of, in part, unspecified convulsions, type two diabetes mellitus with other circulatory complications, and type two diabetes mellitus with diabetic neuropathy.R11's MDS, dated [DATE], documented she was cognitively intact.R11's Care Plan, initiated on 4/25/25, documented she had actual impairment to skin integrity with interventions of, in part, for staff to administer treatments as ordered and monitor for effectiveness dated 5/1/25. R11's Care Plan, initiated on 7/13/26, documented she had an infection of (staph) to wound of right heel with interventions added on 7/20/26 for doctor to follow wound care and give antibiotics as ordered by doctor.R11's Orders, dated 7/20/26, documented to apply antifungal powder under bilateral breasts until Verbal Miconazole powder comes from pharmacy every day and night shift for Wound.R11's Culture, dated 7/13/26, documented R11's right heel wound had proteus mirabilis and staphylococcus aureus.V17's Follow Up note, dated 6/18/26, documented she was seen after nursing alerted of concerns regarding findings of a new heel wound and increased pain to her right foot. Wound care nurse notified, and new orders were entered for right foot/heel x-rays and to start Doxycycline twice daily for 7 days due to history of diabetes, foot wounds, and amputation. The note continued to document new orders were entered for right foot/heel imaging to rule out possible osteomyelitis and wound care nurse was also made aware.V17's Follow Up note, dated 7/13/26, documented R11 reports concerns related to right heel wound and it possibly worsening. The note continued to document R11 reports that the dressing is not being changed daily, especially over the weekend. Treatment/dressing orders are in place for daily and PRN (as needed). R11 also reports that on one occasion only the dressing was changed, and the wound was not cleansed as ordered. Spoke with nursing regarding dressing changes and wound appearance. It was reported that when she had last changed the dressing and observed the wound, she felt it was similar in appearance with less drainage and minimal odor. It was mentioned, however, that the wound was observed after R11 had received her shower. A wound culture was already obtained, resulted today showing growth of heavy proteus Mirabilis and scant staphylococcus aureus. New order entered for Rocephin 2gm (gram) IV (intravenous) every 24 hours for 7 days.R11's June 2026 Treatment Administration Record (TAR) documented wound care for her right heel was not signed off as completed on 6/27/26 and 6/29/26.R11's July TAR documented she did not get wound care to her right heel signed off as completed on 7/1/26, 7/4/26, 7/8/26, 7/9/26, the evening of 7/18/26, or the mornings of 7/21/26 and 7/22/26. It continued to document R11 had no active wound care orders in place on 7/7/26 and did not get care signed off on that day.On 7/20/26 at 11:34 AM, R11's wound care was completed by V8 (wound nurse). V8 stated R11 has staph in her heel and is on contact isolation for that. V8 stated she could not find R11's powder to put under her breasts, if she can't find it in the cart she will have to reorder it. V8 stated she will have to wait on doing wound care to R11's breast right now since she can't find the powder. V8 stated she keeps meaning to get her wound cart organized better but it's a mess. At 11:36 AM, V8 stated she could not find R11's powder, still looking. R11 stated the staff don't always wear their gowns and gloves when providing care and the staff sometimes forget to do her (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer intravenous antibiotics to treat osteomyelitis in 1 of 3 residents (R7) reviewed for Medication Errors in a sample of 17. Findings include: R7's Facesheet, with a print date of 7/22/26, documented she was admitted to the facility on [DATE] with diagnosis of, in part, type two diabetes mellitus with foot ulcer, complete traumatic amputation of one unspecified lesser toe, and osteomyelitis. R7's Minimum Data Set (MDS), dated [DATE], documented she was cognitively intact. R7's Care Plan, initiated on 7/20/26, documented R7 is on IV (intravenous) medications/antibiotics related to Osteomyelitis with interventions for staff to administer medications as ordered by doctor. R7's Orders started on 7/9/26 documented Cefepime HCl Intravenous Solution 2 GM (gram)/100ML (milliliters), Use 2 gram intravenously every 12 hours related to osteomyelitis until 7/29/26. R7's July Medication Administration Record (MAR) documented on 7/20/26 for her 9:00 PM dose of Cefepime HCL a number 6 indicating to see progress notes on administration for the medication. R7's Progress Notes, dated 7/20/26 at 9:13 PM, documented there was no RN (Registered Nurse) to administer R7's Cefepime HCl intravenously. On 7/22/26 at 8:55 AM, R7 stated they need more night shift RNs (Registered Nurses) the other night she missed her IV antibiotics because there was no RN working. On 7/22/26 at 12:06 PM, V17 (NP/Nurse Practitioner) stated IV antibiotics for osteomyelitis are important to get. V17 stated she was not made aware that R7 missed a dose of her IV antibiotic the other night because there was no RN on duty. On 7/22/26 at 2:20 PM, V1 (Administrator) stated she expects the nurses to be following wound care orders as written and medications to be administered as ordered. V1 stated R7 missed her IV antibiotic a couple nights ago because there was no RN working. The facility's Physician Orders policy, dated 7/2025, documented drugs will be administered upon a clean, complete and signed order of a person lawfully authorized to prescribe.		

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 07/27/2026
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 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 perform hand hygiene and follow Enhanced Barrier Precautions (EBP) for 3 of 6 residents (R15, R16, R13); reviewed for Infection Control in a sample of 17. Findings include: 1. R15's Facesheet, with a print date of 7/22/26, documented she was admitted to the facility on [DATE]. On 7/22/26 at 8:50 AM, V15 (Licensed Practical Nurse/LPN) administered R15's Insulin injection to her right up extremity without gloves or gown in place. R15's door has EBP sign. 2. R16's Facesheet, with a print date of 6/22/26, documented she was admitted to the facility on [DATE]. On 7/22/26 at 9:00 AM, V16 (pulmonary LPN) was completing pulmonary care with R16 at her bedside. V16 did not complete hand hygiene after leaving R16's room. On 7/22/26 at 12:06 PM, V17 (NP/Nurse Practitioner) stated she expects EBP to be followed to prevent the spread of infections. On 7/22/26 at 1:23 PM, V16 (pulmonary LPN) stated, If EBP is on the door you are supposed to follow precautions with gown and gloves when providing high contact care as listed. V16 stated she's not sure exactly who is on EBP, when referring to R14 or R15. On 7/22/26 at 11:32 AM, V18 (Infection Preventionist) stated EBP is put in place to prevent further infections for residents, and she expects the staff to be maintaining it. On 7/22/26 at 1:25 PM, V2, Director of Nursing, stated she is not sure who is on EBP, when referring to R14 and R15, after reviewing their charts. Minutes later V2 stated R15 should be on EBP due to her blood glucose monitoring device. On 7/22/26 at 2:20 PM, V1, Administrator stated she noticed they have in-servicing to do on infection control measures. 3 On 7/22/2026 at 9:16AM, R13 observed in bathroom in his room with gait belt around his waist and walker in front of him. R13 assisted to stand by V11, Physical Therapy Assistant (PTA). V11 did not have a gown on, but did have gloves on. V11 instructed R13 to finish pulling up his pants. V11 then assisted R13 with gait belt and walker to the hallway. V11 removed gloves but did not sanitize hands after removing gloves. There is a sign posted on the outside door of R13's room, Enhanced Barrier Precautions. R13's physician orders sheet (POS), dated 6/23/2026, documents Enhanced Barrier Precautions: ostomy every shift. (continued on next page)		

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 07/27/2026
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's care plan, dated 6/12/202,6 documents R13 has an ostomy related to volvulus. On 7/22/2026 at 11:07AM, V11, PTA, stated a gown and gloves are to be worn when transferring a resident or assisting with toileting. V11 stated hands are to be washed prior to exiting room. The Center for Disease Control (CDC)Enhanced Barrier Precautions, undated documents Stop; enhanced Barrier Precautions Everyone Must: clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities; Transferring, changing briefs or assisting with toileting.		