STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 - 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** 44556 Based on interview and record review, the facility failed to prevent the verbal and physical resident to resident abuse for 4 of 4 residents (R17, R31, R32, R49) reviewed for abuse in the sample of 57. This failure resulted in R49 grabbing a large fist of R32's hair and pulling it out of her scalp. Findings include: 1. R32's Admission Record, with an original admitted [DATE], documents R32 has diagnoses of, but not limited to: Alzheimer's Disease, Type II Diabetes Mellitus, and Hypertension (HTN). R32's Minimum Data Set (MDS), dated [DATE], documented R32 is severely cognitively impaired and requires partial/moderate assistance with oral hygiene, upper and lower body dressing, substantial/maximal assistance with toileting hygiene, putting on/take off footwear, personal hygiene, dependent on staff with shower/bathe, and she is always incontinent of bowel and bladder. R32's Care Plan, dated 09/26/24, was reviewed, and no documentation was noted regarding R32 being at risk for abuse. R49's Admission Record, with an original admitted [DATE], documented R49 has diagnoses of but not limited to diastolic congestive heart failure (CHF), Type II diabetes mellites with chronic kidney disease, end stage renal disease, dependence on renal dialysis, and dementia. R49's MDS, dated [DATE], documented R49 is severely cognitively impaired with a Brief Interview for Mental Status (BIMS) of 07 out of 15, and he requires setup/clean up assistance with his activities of daily living (ADL) and is independent with bed mobility and transfers. The facility's Illinois Department of Public Health (IDPH) initial investigation, dated 09/21/24 at 4:32 PM, documented, the administrator was notified at 3:55 PM of an incident that had just occurred between resident (R32) and (R49). (R49) allegedly pulled (R32's) hair, the two residents were immediately separated, Power of Attorney (POA), Primary Care Physician (PCP), Ombudsman, and local police department were notified of incident. Licensed nurse performed head to toe assessment. Investigation started and final report to follow. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 - Actual harm Residents Affected - Few	R32's Progress Notes, dated 09/21/24 at 4:01 PM, was reviewed and documented, Situation, Background, Assessment, and Recommendation (SBAR) (R32) was harmed by another resident (R49) at the facility. (R32) noted to wander into (R49's) room. Writer was at the nurse's station when they heard yelling coming from (R49's) room. The writer entered (R49's) room (R49) was noted to have pulled out a fist full of (R32's) hair. Both residents were immediately separated with the help from the other nurses on duty. Vital signs (VS) taken/range of motion (ROM)/Neuros within normal limits (WNL). (V1, Administrator) was called and notified. (R32's) husband and physician were notified. R49's Progress Notes, dated 09/21/24 at 4:34 PM, documented SBAR assessment for further information and family/physician notification. The change in condition the resident is currently experiencing is Resident to Resident event. (R49) noted to harm another resident. Writer was at the nurse's station when he heard yelling coming from (R49's) room. Writer and CNA went into (R49's) room and found (R49) ripped out a chunk of another resident's hair. Residents were immediately separated with help from other nurses on duty. (V1, Administrator) and (V77, Nurse Practitioner), was called and notified with new order (N.O.) to monitor patient 1:1. Attempted to call (R49's) guardian unable to reach, voicemail (vm) left. V69, Licensed Practical Nurse (LPN), statement, undated, documented on Saturday 09/21/24 a CNA stepped off of the 100-hallway to request additional assistance from of the other nurses in the facility. When V69, Licensed Practical Nurse (LPN) arrived at the unit she noted a large mass of hair lying on the floor outside of R49's room. V72, LPN was in the room with R32. R49 was walking down the hallway with a CNA and his face was red with an angry expression. V69 said she went into R49's room, and R32 was observed sitting on the floor between bed one and two with her back up against bed two, and some of R32's hair was noted to be at the foot of bed two. V69 said she checked the back of R32's head, there was no bleeding noted, but there was a large bald patch in the back of her scalp. Vital signs (VS) obtained, range of motion (ROM) within normal limits (WNL). V69 and the CNA assisted R32 up the CNA and another nurse assisted R32 to the toilet. On 09/25/24 at 2:37 PM, R32 was sitting outside in the courtyard with other residents. R32's hair/head was observed, and there was an approximate softball size area on the back of R32's head where she had hair missing. On 09/25/24 at 2:40 PM, V9, Certified Nursing Assistant (CNA), and V25, CNA, stated R32 usually has thick hair. V25 said when she came into work yesterday, she asked other staff what had happened to R32, and they told her staff heard a scream and went down the hall and they found R32 on the floor, and they had to pull R49 off R32, and he had her hair in his hands. She said R49 has threatened other resident's before, but he has never actually done anything to anyone. V25 stated R32 does wander on the unit. V25 said she is glad R49 is in the hospital at this time, because she is scared something else would happen. On 09/25/24 at 2:27 PM, V2, Director of Nursing (DON) and V33, Regional Director, stated they would expect staff to provide activities, attempt to keep them separated, if possible, redirect frequently, and to use the intervention they put into place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 - Actual harm Residents Affected - Few	The facility Abuse, Prevention and Prohibition Policy, revision date of 1/24, documented Statement of Intent: 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. It continues, Resident to Resident Altercations: Resident to Resident abuse includes the term willful. The word willful means that the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. 49494 2. R31's Face Sheet, dated 9/24/24, documented R31 has diagnoses of COPD (Chronic Obstructive Pulmonary Disease), benign prostatic hyperplasia, muscle weakness, hyperlipidemia, PTSD (post-traumatic stress disorder), depression, hypertension, obstructive and reflux uropathy, chronic migraine, and low back pain. R31's MDS, dated [DATE], documents R31 is cognitively intact. R31's Care Plan, print date 9/17/24, documents R31 has a behavior problem related to cursing about his loss of independence and showing signs of frustration. The Care Plan documents R31 suffers from PTSD related to his military background. R31's care plan documented R31 will show signs of PTSD and staff interventions could include: 1. Ensuring resident's and other residents' safety while PTSD is displayed. R17's Face Sheet, dated 9/24/24, documented resident has diagnoses of end stage renal disease, type 2 diabetes mellitus, psychotic disorder with delusions, pseudobulbar affect, muscle weakness, anxiety disorder, major depressive disorder, auditory hallucinations, cerebral infarction, schizophrenia, cognitive communication deficit, legal blindness, cardiomyopathy, heart failure, and hypertension. R17's MDS, dated [DATE], documented resident is moderately cognitively impaired. R17's care plan, print date 9/24/24, documented R17 has a mood problem related to depression and anxiety. R31's Progress Note, dated 8/30/24 at 5:16 PM, documented Patient made threatening comments about the neighbor patient yelling. Stating 'if she keeps doing it, I am going to shove a sock down her throat.' Education provided about behaviors and how legal action would be taken if such an event happened. Patient stated, 'I don't give a s***.' R31's Progress Note, dated 9/2/24 at 5:58 PM, documented, (R31) was in the hallway at this nurse's med cart to get medications when another resident, that was sitting in her room, started hollering. (R31) hollered loudly, Shut the f*** up. The other resident stated, you shut up you mother *****. This resident states, shut the f *** up or I will come in there and rip your f****** throat out. This nurse tried to calm resident and explain to him that he cannot talk to other residents that way. Resident wheeled down the hall to go outside. (V1, Administrator) and Doctor (V20) notified. Will continue to monitor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 - Actual harm Residents Affected - Few	The Facility's Investigation, undated, documented the Administrator was notified of an incident involving R31 and R17. Staff members reported that R31 yelled at R17 to shut the f*** up and R17 yelled back calling him a mother f*****. R31 then yelled at R17 that he would cut her throat out. On 9/19/24 at 7:55 AM, V38, Certified Nurse's Aide/CNA, stated she was working the night R31 and R17 verbally abused one another, but she did not witness it. V38 stated another coworker told her about the occurrence, and she does not know what intervention was put into place to keep it from happening again. On 9/19/24 at 9:02 AM, V19, CNA, stated she witnessed the abuse incident between R31 and R17 on 9/2/24. V19 stated she heard R31 yell at R17 that he was going to slit her throat. V19 stated she does not know what intervention was put into place to prevent this from happening again.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on observation, interview, and record review, the facility failed to protect residents during abuse investigations to prevent further potential abuse from occurring for 2 of 4 residents (R17, R31) residents reviewed for investigation/prevention/correct alleged violation of abuse in a sample of 57. Findings include: R31's face sheet, dated 9/24/24, documented R31 has diagnoses of COPD (Chronic Obstructive Pulmonary Disease), benign prostatic hyperplasia, muscle weakness, hyperlipidemia, PTSD (post-traumatic stress disorder), depression, hypertension, obstructive and reflux uropathy, chronic migraine, and low back pain. R31's Minimum Data Set (MDS), dated [DATE], documented R31 is cognitively intact. R31's Care Plan, print date of 9/17/24, documented R31 has a behavior problem related to cursing about his loss of independence and showing signs of frustration. R31 suffers from PTSD related to his military background. R31's care plan documented R31 will show signs of PTSD and staff interventions could include: 1. Ensuring resident's and other residents' safety while PTSD is displayed. R17's Face Sheet, dated 9/24/24, documented resident has diagnoses of end stage renal disease, type 2 diabetes mellitus, psychotic disorder with delusions, pseudobulbar affect, muscle weakness, anxiety disorder, major depressive disorder, auditory hallucinations, cerebral infarction, schizophrenia, cognitive communication deficit, legal blindness, cardiomyopathy, heart failure, and hypertension. R17's MDS, dated [DATE], documented resident is moderately cognitively impaired. R17's Care Plan, print date of 9/24/24, documented R17 has a mood problem related to depression and anxiety. R31's Progress Note, dated 8/30/24 at 5:16 PM, documented patient made threatening comments about the neighbor patient yelling. Stating if she keeps doing it, I am going to shove a sock down her throat. Education provided about behaviors and how legal action would be taken if such an event happened. Patient stated, I don't give a s***. R31's Progress Note, dated 9/2/24 at 5:58 PM, documented, (R31) was in the hallway at this nurse's med cart to get medications when another resident, that was sitting in her room, started hollering. (R31) hollered loudly, Shut the f*** up. The other resident stated, you shut up you mother **** **. This resident states, shut the f *** up or I will come in there and rip your f****** throat out. This nurse tried to calm resident and explain to him that he cannot talk to other residents that way. Resident wheeled down the hall to go outside. (V1, Administrator) and Doctor (V20) notified. Will continue to monitor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility investigation, undated, documented the Administrator was notified of an incident involving R31 and R17. Staff members reported that R31 yelled at R17 to shut the f*** up and R17 yelled back calling him a mother f*****, R31 then yelled at R17 that he would cut her throat out. This investigation documented both residents' care plans were reviewed and updated. R31 was given instructions to ask staff for assistance if he hears a resident yell out and not to yell back. The resident voiced an understanding. If it continues, Social Services will visit with R31 and R17 twice weekly for 30 days. R17's Care Plan, print date of 9/24/24, did not document how the facility will prevent R17 from any further abuse, and did not document anything regarding Social Service conducting visits with R17 twice weekly for 30 days following. R17's Social Service progress notes from 9/2/24 to 9/19/24 do not document any Social Services visits. R31's Care Plan, print date of 9/24/24, did not document how the facility will prevent R31 from being verbally abusive towards other residents. R31's Social Service progress notes from 9/2/24 to 9/19/24 do not document Social Service is meeting with R31 twice weekly as documented as the intervention to the 9/2/24 abuse investigation of R31 and R17. Throughout the survey from 9/16 through 9/26/24, R17 remained in a room two doors down, across the hall from R31. R31 must pass R17's room to go to nurse's station, courtyard, dining room, activities, and shower. On 9/18/24 at 9:15 AM, V22, Certified Nurse Assistant, (CNA) stated she just kind of monitors R17 and R31 since the abuse incident. V22 stated she has not been told about any other interventions that are in place to prevent any further abuse from occurring between R17 and R31. V22 stated R17 sometimes sings or hollers out and that makes R31 angry. On 9/18/24 at 9:18 AM V21, CNA, stated neither R17 nor R31 have been moved to a different hall since the abuse occurred between them. V21 stated she is not aware of any interventions in place to prevent abuse from occurring again between R17 and R31. V21 stated neither R17 nor R31 were moved to another hall after the abuse occurred between them on 9/2/24. On 9/18/24 at 9:45 AM, V14, Social Service Director, stated she does not meet with R31 any certain number of times per week. V14 stated R31 stops in her office frequently, but she does not document that. V14 stated she is not aware of what intervention was put into place to prevent abuse from occurring again between R17 and R31. On 9/19/24 at 7:45 AM, V14, Social Service Director, stated she does not meet with R17 unless there is a reason. V14 stated she does not know what the facility is doing to prevent R31 from verbally abusing R17. On 9/19/24 at 9:02 AM V40, CNA, stated she was working the evening that R31 yelled and cursed at R17. V40 stated she heard R31 curse and yell that he was going to slit R17's throat. V40 stated she closed R17's door, and then R31 went outside. V40 stated she does not know what intervention the facility put into place to try and prevent this from happening again. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/24 2:25 PM V1, Administrator, stated she expected V14, Social Service Director, to be meeting with R31 and R17 twice weekly as documented in the facility resident to resident abuse investigation, and she would expect V14 to document these meetings in the EMR (Electronic Medical Record). The facility Abuse, Prevention, and Prohibition Policy, revision date of 1/24/24, documented each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected 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. It continues, prevention: The resident has the right to be free from verbal, mental, sexual, exploitation, or physical abuse; corporal punishment and involuntary seclusion. The owner, licensee, Administrator, employee, or agent of the facility shall not abuse or neglect a resident and must prohibit the misappropriation of resident property. Resident behaviors will be monitored for changes, which trigger abuse behaviors. The facility will reassess care plan interventions on a regular basis. Intervention strategies based on resident screenings will be implemented to prevent occurrences of abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on interview and record review, the facility failed to document in the resident's Electronic Medical Record (EMR) the reason for discharge, failed to provide written documentation of the reason for discharge and resident rights to appeal the discharge to for 1 of 3 residents (R20) residents reviewed for discharge in a sample of 57. Findings include: R20's Face Sheet, dated 9/24/24, documented R20 has diagnoses of pseudarthrosis after fusion, depression, gastro-esophageal reflux disease, osteoarthritis, anxiety disorder, insomnia due to other mental disorder, chronic pain, alcohol dependence, altered mental status, hypertension, hyperlipidemia, hypokalemia, and hypomagnesemia. R20's Minimum Data Set (MDS), dated [DATE], documented R20 is cognitively intact. R20's Care Plan, print date of 9/24/24, does not document any discharge planning. R20's Progress Note, dated 9/10/24 at 10:53 AM, documented resident seems increasingly confused and agitated this morning. Resident states he's in a lot of pain and needs more pain medication. Resident has had his pain meds including his scheduled hydrocodone 10/325 as well as his PRN (as needed) oxycontin. Staff has advised resident the dangers of taking both medications at the same time as well the risk of addiction. Writer went to take resident his requested medication in room and discovered that resident had his room in complete disarray. All drawers were pulled out, clothes taken out of drawers and closet, bed stripped apart, side table flipped over, food scattered on the floor. Writer asked resident was happened in here and resident states not much, I just wanted to change things up. Resident also mentioned he couldn't sleep and wanted to move some things around. Writer warned resident about the dangers of moving furniture and other objects so soon after having back surgery. Resident just shook his head and didn't seem too concerned. Staff will continue to monitor. R20's Progress Note, dated 9/10/24 at 12:09 PM, documented writer called for emergency services for transport to acute facility at this time. R20's Progress Note, dated 9/10/24 at 12:17 PM, documented local EMTs (Emergency Medical Technicians) x 2 in facility for transport at this time. Writer provided brief report re: purpose of transfer; also provided copies of face sheet, current med orders, POLST (physician orders for life sustaining treatment), bed hold and transfer/discharge forms to EMTs. Prior to assisting resident to stretcher, EMTs asked resident if he had sutures or staples r/t (related to) recent surgery, resident responded with slurring I haven't had any surgery yet. R20's transfer form, dated 9/10/24 at 12:33 PM, documented A&O (alert & oriented) x 4, abnl (abnormal) behaviors began this morning. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's investigation of R20's discharge, dated 9/13/24, documented the Administrator spoke with R20 via telephone and explained due to the potential harm he had put his roommate, residents, and staff in by smoking cocaine in his room, he was unable to return. He was told his belongings, including his wallet and phone had been packed up and family could pick them up at any time. When he asked about medications, he was told to ask the hospital for discharge scripts until he could see a physician, and he voiced an understanding and apologized for what had happened. On 9/16/24 at 9 AM, V1, Administrator, stated, (R20) was discharged , and we are not taking him back because he had altered mental status due to consuming cocaine at the facility. We found a rock of it, and a spoon with black marks on it in his room, the police came, got the drugs, tested it, and said it was cocaine. They didn't press charges. We did not notify his wife because she isn't the POA (Power of Attorney) and I just told him over the phone that he cannot come back, I will take the tag. On 9/24/24 at 10:42 AM, V14, Social Service Director, stated she did not do any discharge planning with R20. The facility's Discharge Summary and Plan policy, dated 11/2022, documented the discharge plan will include resident and family/caregiver education needs and will initiate or maintain collaboration between the nursing facility and other post-acute care providers to support the resident's transition to community living. The discharge plan, instructions, & summary provides a recapitulation or summary of the resident's stay. 1. Discharge planning will begin upon admission to the SNF (Skilled Nursing Facility) a. Nursing Admission/Readmission Data Collection - admitting nurse will document the resident, family/caregiver stated reason for admission and the resident. Family/caregiver plan for discharge. 2. 48 Hour Meeting a. Members of the interdisciplinary team will meet with resident and family/caregiver within 48 hours of resident's admission to the SNF to discuss discharge plans. b. Documentation of discharge plan will be completed utilizing the Interdisciplinary Care Conference Note 48 Hour Meeting assessment by Social Service Director of Social Service Designee. 3. Care Plan a. Social Service Director or Social Service Designee will initiate and update the discharge plan in the Care Plan section of the resident's record. 4. Discharge Plan, Instructions, & Summary. a. Social Services Director of Social Service Designee will initiate and update the discharge plan in the Care Plan section of the resident's record. b. The IDT (Interdisciplinary Team) will be notified when the assessment is open and incomplete sections will be discussed in morning meeting. c. Social Service Director or Designee will complete sections A, B, D, H. d. Nursing will complete sections C & E; Wound nurse will ensure skin and treatments ae recorded. e. Dietary will complete section F. f. Activities will complete section G. g. Social Service Director or Social Services Designee will ensure all sections are complete and the document is signed and locked. 5. Discharge Education a. Nurse will review discharge instructions and medications with resident/resident representative. Copy of Disposition of Medication form will be given to resident/resident representative and a copy scanned into the record. b. Social Services Director or designee will include the Discharge Plan, Instructions, and summary in the Discharge Packet. 6. Nurse will document discharge note in the progress notes section of the resident record. Discharge note will include skin assessment, who they discharged with, where they are discharging to, what belongings were sent with them and other pertinent information. 7. Social Services will make post discharge follow up call at 72 hours and complete the Discharge Post Discharge Follow Up Phone Call assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40701 Based on observation, interview and record review, the Facility failed to ensure showers, basic grooming, and feeding assistance were provided for 2 of 24 residents (R33 and R145) reviewed Activities of Daily Living (ADLs) in the sample of 57. Findings include: 1. R145's Face Sheet, dated 9/18/2024, documents R145 was admitted to the facility on [DATE], with a diagnosis of Amyotrophic Lateral Sclerosis (ALS- also known as Lou Gehrigsdisease, is a fatal neurological disorder that causes nerve cells in the brain and spinal cord to die. This leads to muscle weakness, paralysis, and eventually the loss of the ability to breathe and control voluntary movements.) R145's Care Plan, undated, documents R145 has ADL (Activities of Daily Living) self-care performance deficit related to ALS, weakness, and osteoarthritis. R145 is totally dependent on one staff member for toilet use. On 9/17/2024 at 11:13 AM, R145 stated she has been at the Facility since 9/11/2024, and has not had a shower or a bed bath. On 9/17/24 at12:53 PM, R145's lunch tray sat untouched on bedside table. R145 stated she needs assistance with eating because she has severe ALS and nerve damage. R145 stated her right shoulder is also frozen. R145 stated the CNA (Certified Nurse's Aide) told R145 she must deliver trays to everyone else before she can feed her. R145 stated, This is just a mess. On 9/17/24 at 3:36 PM, R145 was observed in the hallway in a shower chair, leaving the shower room, smiling. On 9/17/2024 at approximately 3:45 PM, R145 stated she feels so much better and she even had her hair washed. On 9/18/2024 at 10:00 AM, V2, Director of Nursing, stated she only has one shower sheet for R145. R145's shower sheet was dated 9/17/2024. On 9/18/2024 at 11:17 AM, R145 stated, Nobody has offered to help me brush my teeth. They never help me wash my face. My daughter was here Saturday and helped me brush my teeth. On 9/18/2024 at 11:30 AM, V19, Certified Nursing Assistant (CNA), stated R145 was kind of confused, but V19 gave her a bed bath. V19 stated she didn't fill out a shower sheet. On 9/18/2024 at 3:34 PM, V16, CNA, stated when she was giving R145's shower, R145 told V16 that R145 had not have a shower in two weeks. The Facility's Shower Schedule documents R145 should receive showers on Tuesdays and Fridays on day shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/2024 at 9:34 AM, V2, Director of Nursing, stated they do not have a policy pertaining to ADL's. V2 stated they expect staff to follow the best practice guidelines. 2. R33's MDS, dated [DATE], documents R33 has an ADL Self Care Performance Deficit Fatigue, and requires one staff member participation with personal hygiene and oral care. R33's MDS further documents R33 is cognitively intact. On 9/17/24 at 1:31 PM, V22, CNA, stated she has heard R33 complain about not getting showers. On 9/17/2024 at 1:43 PM, V18, Occupational Therapy, stated R33 told V18 she hadn't had a shower and wanted one to make her feel better. On 9/17/2024 at 2:25 PM, R33 stated she does not usually get her showers like she is supposed to. R33 stated V18 did get her a shower recently. R33 stated, even one shower a week would be alright. The Facility's Shower Schedule documents R33 should get showers on Tuesday evenings and Friday Mornings. On 9/19/2024 at 2:30 PM, V27, CNA, stated residents should get showers twice a week and documented on a shower sheet. On 9/18/2024 at 12:19 PM, the Facility did not provide any shower sheets for R33. On 9/19/2024 at 9:34 AM, V2 stated they do not have a policy pertaining to ADLs. V2 stated they expect staff to follow the best practice guidelines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40701 Based on observation, interview, and record review, the Facility failed to prevent the deterioration of pressure ulcer, the development of a new pressure, and treat pressure ulcers as order by physician for 1 of 2 residents (R85) reviewed for pressure ulcers in the sample of 57. Findings include: 1. R85's Face sheet, dated 9/19/2024, documents R85 was admitted to the facility on [DATE] with a pressure ulcer (site unspecified). R85's Minimum Data Set, dated dated [DATE], documents R85 has one stage 3 (full thickness tissue loss) pressure ulcer. R85's Physician's Order Sheet, dated 9/19/2024, documents, Cleanse open area to sacrum with wound cleanser, pat dry, apply sure prep to surrounding skin. Apply Calcium Alginate to wound bed only, cover with dry dressing daily and as needed. On 9/16/2024 at 11:57 AM, R85 stated he had two open areas on his buttocks. On 9/16/2024 at 1:00 PM, V8, Assistant Director of Nursing, and V36, Wound Nurse, were observed exiting R85's room. V8 stated they had changed R85's dressing to his buttocks. V36 stated R85's wound has gotten deeper. R85's Assessment Report, dated 9/17/24, documents, Sacrum Wound- 2 centimeters (cm) length by 0.8 cm depth by 2 cm width. Depth Status- has deteriorated compared to the conclusion of previous visit. Stage 3. Frequency of dressing change. Daily, as needed for soiling, saturation, or unscheduled removal. On 9/18/2024 at 3:00 PM, V23, Registered Nurse (RN), removed R85's adult brief. R85 had a small amount of feces in his incontinence brief. R85 had no dressing intact to his coccyx area (buttocks). There was no dressing in R85's adult brief either, and this information/observation was confirmed by V23. At this time, R85's right buttocks had a reddened area. When asked about the reddened area, V23 stated, It looks like it's trying to be a new spot (second open area). On 9/18/2024 at 3:30 PM, V37, Certified Nurse's Assistant (CNA), stated if she saw an open area on a resident's skin or the dressing to the area became soiled, she would inform the nurse. On 9/18/2024 at 3:34 PM, V16, CNA, stated she was assigned to R85 on 9/17/2024. V16 stated she provided R85 incontinent care after R85 had a bowel movement. V16 stated R85's dressing to his buttocks was soiled, she removed it, but did not notify the nurse. On 9/18/24 at 4:03 PM, V8 stated R85's banshe changed [NAME] to his buttocks 9/17/2024 between 12:30 PM and 2 PM, and it was secure in place. V8 stated she would expect staff to notify the nurse if the bandage becomes soiled and/or is not intact. V8 stated R85's bandage should be intact continuously per physician's orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Wound Care System Requirements Policy, dated 3/2022, documents, Treatment orders are being completed as orders, and are changed if no progress is noted in two weeks. The Facility's Skin Checks Policy, dated 3/2022, documents, Any new wounds or skin conditions will be assessed by the nurse by the nurse finding the wound or skin issue.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44556 Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent elopements for 1 of 8 residents (R49) reviewed for supervision to prevent elopements in a sample of 57. This failure resulted in an Immediate Jeopardy when on 8/17/24 at an unknown time, R49, who has a known history of elopement attempts and dementia, eloped from the facility without staff knowledge and was located 60 miles away from the facility. The Immediate Jeopardy began on 08/17/24 when R49 eloped from the facility without staff knowledge. R49 was last seen in the facility on 8/17/24 at 11:30 , and was found 60 miles away at his past home residence. Due to R49's physical and cognitive vulnerabilities, R49 had the likelihood of serious harm and injury when R49 eloped. V1, Administrator, and V33, Regional Director, were notified of the Immediate Jeopardy on 09/19/24 at 2:00 PM. Surveyors confirmed by observation, record review, and interview, the Immediate Jeopardy was removed 9/23/24 but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of staff's in-service training, and implementation of interventions for those at risk for elopement. Findings include: R49's Admission Record, with an original admitted [DATE], documented R49 has diagnoses of, but not limited to: diastolic congestive heart failure (CHF), Type II diabetes mellites with chronic kidney disease, repeated falls, end stage renal disease, dependence on renal dialysis, and dementia. R49's Minimum Data Set (MDS), dated [DATE], documented R49 is severely cognitively impaired with a Brief Interview for Mental Status (BIMS) of 07 out of 15, and he requires setup/clean up assistance with his activities of daily living (ADL) and is independent with bed mobility and transfers. R49's Elopement Assessment, dated 03/11/24, documented R49 was cognitively impaired, and was not at risk for elopement. R49's Progress Note, dated 04/06/24 at 16:23 (4:23 PM), documented Front door alarm was sounding. Writer was on the hall and went to the front door to check on alarm. Nobody was standing at the front door. Writer went outside to investigate who set the alarm off. Resident was walking back toward front door with walker with CNA (Certified Nursing Assistant) assisting him. CNA was outside returning from break when she noted this resident walking outside in front of the building to the facility van by himself. CNA was assisting resident back inside. Writer stayed with resident and CNA. Resident noted to have confusion and said he needed to meet at the van because the girl that gives rides was going to bring him home. Resident assisted back into facility without incident. Resident's nurse was updated. Resident went to his room to rest for a little while. R49's Elopement Assessment, dated 05/01/24, documented R49 is cognitively impaired, has history of elopement, desire to leave the facility, and anger issues relate to placement in the facility. It also documented, What interventions were put in place to prevent resident from eloping? Picture in elopement book, frequent visual monitoring, and provided with distracting activity. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R49's Care Plan, print date of 09/19/24, documented Date Initiated: 05/01/2024, Focus: (R49) is an elopement risk/wanderer as evidence by (AEB) history of attempts to leave facility unattended. He believes someone is coming to take him home. Goal: The resident will not leave facility unattended, and the resident's safety will be maintained through the review date. Interventions include but are not limited to Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate and resident not allowed outside of community independently, initiated on 04/06/24. R49's Progress Notes, dated 05/09/2024 at 03:33 PM, documented Dialysis called and informed staff that patient (R49) was restless and attempting to leave. Did complete his treatment. Dialysis staff is requesting a possible sitter to be with patient during treatments. R49's Progress Notes, dated 05/10/2024 at 09:34 AM, documented the Social Worker from dialysis called the facility to make them aware R49 is exit seeking at their facility and he attempted to get in someone's vehicle, and she wanted to discuss the situation over with V14, Social Services, and see what they can come up with for a solution. R49's Progress Notes, dated 05/17/2024 at 01: 06 PM, documented dialysis called V14, Social Services, to express a concern with the elopements and agitation they are experiencing with R49 when he goes to dialysis. Dialysis informed V14 there is a policy in place that states in a circumstance such as this, the facility is to supply a sitter for R49 as he takes dialysis. V1, Administrator, states the facility will have a sitter for tomorrow's services as it is one of his scheduled days. R49's Progress Notes, dated 08/16/2024 at 02:04 PM, documented R49 was going outside facility in courtyard. Writer reminded R49 he was not supposed to be going outside without supervision, he became upset, was yelling at staff to leave him alone, and refused to come back inside the facility. On 09/18/24 at 09:25 AM, V24, Licensed Practical Nurse (LPN), stated before the incident on 8/17/24, she had seen R49 go out the back door where the smokers sit, and she explained to him that he needed supervision while he was outside. She said if they have someone who tries to get out the doors have alarms on them and will sound. R49's Progress Notes, dated 08/17/24 at 01:30 PM, documented elopement reported to writer and elopement policy followed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R49's Police Report, dated 08/17/24 at 2:01 PM, was reviewed and documented, (V53, Local Police Officer), was dispatched to the report of a missing person at a local nursing facility. At approximately 2:09 PM, (V53) arrived at the facility where numerous staff were searching nearby areas for (R49), and two county officers (V54 and V55) were already on scene. (V54) had already spoke with (V1, Administrator) and got all (R49's) personal information and what he was last seen wearing. Dispatch had advised (V53) there was a possibility (R49) was with his wife (V30). (V1) was asked if (R49) had left on foot and (V1) advised (V53) that no one had seen (V30, R49's wife), but they have had numerous issues with her wanting to take (R49) in the past. (R49) has limited mobility, and his wheelchair was still in his room, so more than likely (R49) was with (V30). (V1) had informed the officers (R49) had a legal court appointed guardian (V31), and he wasn't supposed to leave the facility. (V1) also stated (V30) was allowed to visit (R49), but she was aware she was not allowed to take him. (V54) had the local county telecommunicators obtain (V30's) vehicles registration information. Once (V54) had the car information he checked them with the License Plate Readers (LPR) located in the county and had two responses, one at 10:07 AM in another town, and one locally at 10:21 AM. (V54) had the local sheriff's office reach out to the county sheriff's office where (V30) resides to see if (R49) and (V30) were there. (V54) and (V55) cleared the scene and (V1) wished to enter (R49) as a missing person. At approximately 2:45 PM the next county sheriff's office made contact with the local sheriff's office and stated that a deputy had made contact with (V30) at her home where she told the deputy that (R49) is here he needs to be and slammed the door in the deputy's face. At approximately 5:41 PM (V56, [NAME] for the other sheriff's office) contacted (V53) and informed him they had (R49) in their custody now after locating him at (V30's) residence. (V1, Administrator) then asked the police and sheriff's office to take (R49) to the local hospital to be evaluated prior to coming back to the facility. At approximately 6:24 PM, (V1) was updated on (R49) and told he was being taken to a local hospital and that the facility would have to transport (R49) back to the facility themselves. R49's Illinois Department of Public Health (IDPH) Elopement Investigation, dated 08/17/24, documents, at approximately 1:30 PM, documented this letter is to notify the department of a final report regarding a resident that was possibly missing from the facility. On 08/17/24 at approximately 1:30 PM a licensed staff reported to the administrator that staff were not able to locate (R49), the Elopement policy was implemented immediately, and an investigation was initiated. (R49's) physician and guardian along with the ombudsman and police department were notified. (R49) is alert with confusion and has a BIMS (Brief Interview for Mental Status) of 7 and he needs assistance with his ADLs. (R49) has diagnose of dementia, anemia, diabetic, depression, HTN (hypertension), and receives dialysis treatment The staff immediately started searching the facility and the facility grounds and then extended the search per policy. A 100% head count was completed validating all residents were accounted for. A staff member was designated to imitate a timeline of events. The police were provided with a description of the resident and the clothing he was wearing. Attempts were made to contact the resident's spouse, and a message was left to call the facility back. The police contacted the administrator and reported they were able to ping the resident's spouse car indicating she was in a town not far from the facility. Staff were interviewed, they stated they did not witness resident's spouse in the facility, residents were interviewed, and they had no knowledge of residents leaving the facility. At 3:25 PM the police department notified V1, administrator that (R49) was with his spouse at their residence in another town. The police reported they knocked on the door, (V30) answered the door, and then closed the door on the police. The police notified the facility at approximately 5:50 PM they were able to talk with (V30) and (R49) left the residence with the police officers without incident. The police department stated they wouldn't be transporting (R49) back to the facility. (V1) requested (R49) be taken to the hospital for an assessment and the facility would provide transportation back to the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R49's Elopement Assessment, dated 08/18/24, documented R49 is cognitively impaired, has history of elopement, desire to leave the facility, and anger issues relate to placement in the facility. It also documented What interventions were put in place to prevent resident from eloping? Picture in elopement book, frequent visual monitoring, provided with distracting activity, and moved resident to a secured unit. R49's Care Plan was updated to include the following information after his elopement on 08/17/24. R49 has been moved to the memory care unit, 1:1 supervision times 24 hours, if no issues, R49 will change to visual checks every 15 minutes times 24 hours, if no issues, they will chant to visual checks every 30 minutes times 24 hours, and if not issues R49 will be re-evaluated at that time. Resident is not allowed outside of community independently, and R49 has a past history of plotting a plan to leave the facility with V30. Staff should observe for this behavior and prevent it from happening. 09/17/24 02:14 PM, V31, State Appointed Guardian, stated she is a lawyer in a surrounding county and was appointed by the court to be R49's legal guardian due to there not being anyone else to do it. She said on the day of the incident, she received 2 missed calls that she believes was from the facility, but there were no messages left. She said she doesn't answer numbers she doesn't recognize on the weekends, but if they would have left a message, she would have called them back. V31 said when she returned to work on Monday after the incident, she had 2 or 3 emails from the facility regarding R49 leaving the facility. She said from what she knows, the wife came into the facility after parking in the hospital parking lot. She (wife) got R49 up and walked him back to her car. Wife confirmed it with her too. She said the facility called law enforcement and they were dispatched to the county where his wife had taken him back home. She said his wife had a standoff with the police and slammed the door in the police officers face. V31 said his wife (V30) eventually opened the door and let law enforcement in, and they were able to get R49 out of the house. The facility requested R49 be taken to the emergency room (ER) to be cleared before he was taken back to the facility. V31 said she became involved when there was a founded case of neglect made by adult protective services, they filed a petition for public guardian because there wasn't anyone to care for him. After the incident with his wife taking him home, an order of protection/restraining order was put into place. On 09/17/24 at 3:25 PM, this surveyor knocked on R49's door, introduced self, and asked if I could ask him a few questions. R49 said to come on in and have a seat. R49 was asked if he remembered the incident in August when he went home with his wife. He said he thinks he remembers it. This surveyor asked if R49 could tell me about it. R49 stated his wife parked over at the hospital parking lot, he walked up the hill, met her in the car, and they went home. He was asked if his wife came over to the facility and got him and he said no, they had made plans a while ago to do this. He said but the straw that broke the camel's back was he went into Social Services (V14) and asked when they were going to release him, and she told him he wasn't going to be released until the end of January. He said he can't leave his wife for that long; she depends on him. When questioned how he knew when to go over to meet his wife and how she knew what time to be there to get him R49 stated he had to call her to let her know. He said they went home, then the police came to get him, and so there wouldn't be any ramifications for his wife, he returned to the facility. R49 said after this, the District Attorney forbid him to talk to his wife, and if he did there would be consequences. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 09/18/24 at 10:21 AM, V14, Social Services, was interviewed at this time about the conversation she had with R49 the day before he eloped. V14 stated she came in and made rounds like she does every day. She said R49 was lying in bed, and she asked him how he was doing. V14 said he was going on about what is going on with him and court, and how he hates it. She said she tried to get him to go out to activities and he just acted like he didn't hear her, and he just laid back down in his bed. V14 stated she never had a conversation with R49 that day about discharging him. She said when it comes to talking with him about discharges, she watches what she says because she doesn't want to get his hopes up just to let him down. V14 said she was working on the day of the incident and that she had just come in to help by taking residents to their appointments (dialysis). V14 said she was between transports when they notified her they couldn't find R49. V14 said the CNAs were prepping for lunch when they noticed they couldn't find R49. She said they made the call over the intercom and began searching for R49 and she immediately started the elopement process, called V1, Administrator and V2, Director of Nursing. V14 stated if someone is an elopement risk, they would be in the elopement book. She said R49 use to sit up by the front door area and just hover around, and he would think every vehicle that he saw was here to pick him up. She said as far as she knows, R49 had never tried to elope before this incident. V14 said she has talked with Adult Protective Services (APS), and she was informed by them that there were issues with R49's previous living conditions. She said they told her there was a substantiated neglect case involving V30, R49's wife. V14 said there were issues when APS went to talk with V30, and she wouldn't let them in the house. V14 said when APS was finally able to enter the house, they found the house was in deplorable conditions. She said they told her there was feces lying around the house, lack of food, some safety issues regarding R49 using the stove by himself and leaving it on for multiple hours, and R49 not making it to his dialysis appointments. They said the wife was showing signs of confusion; that is how APS got involved in the situation. Their son/daughter notified APS and telling them their mom was very confused, agitated, and all over the place. On 09/18/24 at 10:45 AM, V1, Administrator, was interviewed at this time regarding the elopement of R49. She said she wasn't in the facility at the time of R49's elopement. She said when staff discovered R49 was not able to be located they notified her, and she immediately came in. She said they called 911, and the staff then searched the outside of the facility. She said the police and the local county sheriff's department even came out and helped with the search. V1 said V30 was known to come to the facility on the weekend or in the late evening to see R49. V1 said the police were able to look at cameras and they got a ping for V30, and she was headed toward the facility, so they then notified other police departments about the situation. She said they sent police to V30's house and when they got there V30 wouldn't let them in, and she slammed the door in their face. V1 said the police were finally able to get R49 out of the house, and she wanted R49 checked out at the hospital before coming back to the facility. V1 stated she doesn't recall R49 having eloped from the facility any time prior to this incident. V1 said she doesn't know much about R49 and the APS situation. She said all she really knows is R49 was deemed not safe at home with V30. V1 said prior to this incident, V30 was able to talk with and come and visit R49, but now there is an order of protection, and they are not supposed to have any contact with each other. V1 stated since the order of protection (OOP), V30 tried to come and visit one time, but the police were called immediately, and she was removed. On 09/18/24 at 11:07 AM, V1, Administrator, stated the facility doesn't use electronic monitoring devices. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	09/19/24 10:35 AM, V65, CNA, stated the other CNA (V66) that was working on 08/17/24 with her, was the one who noticed R49 was not able to be found. V65 stated V66 noticed around lunch time, and came and told her she thinks R49 is gone. V65 said she knew he wasn't gone to dialysis, so they looked at the sign out book, didn't see where anyone had signed R49 out, so they checked with R49's friend to see if he had seen him, but he hadn't, so they immediately started working together checking the hallways, they did a head count, and then they did a sweep outside of the building, but were still unable to locate R49. V65 stated they don't know what door R49 went out and no identified alarms went off that she knows of. On 09/25/24 at 2:27 PM, V2, Director of Nursing (DON), and V33, Regional Director, stated they would expect staff to supervise the individuals who were an elopement risk. Monitor with supervision and make sure their care plans are up to date. On 09/18/24 at 02:02 PM, V32, V29's Nurse/ Licensed Practical Nurse (LPN), called this surveyor back and stated she had spoken with V29, R49's primary care physician (PCP), at the time of the incident, and asked him if he thought R49 would be safe outside of the facility by himself, and remember to take his medications and to go to his dialysis appointments? V32 said V29 stated, no he does not think R49 would be safe outside of the facility by himself and doesn't think he would remember to take his medication or go to his dialysis appointments. The facility's Elopement policy, with a reviewed date of 05/2023, documents, Policy It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for elopement. All residents so identified will have these issues addressed in their individual care plans. Responsibility All staff is responsible. Definitions For the purpose of this policy, missing resident shall be defined to mean a resident who has left the facility grounds without signing him/herself out of the facility. It also documents Environmental Considerations for the Prevention of Missing Residents and Elopements. 1. Residents who are at risk for elopement shall be provided at least one of the following safety precautions by the facility: Door alarms on facility exits; and /or a personal safety device that will alert facility staff when the resident has left the building without supervision (i.e.: Code Alert or Wander guard bracelet/anklet system); and/or staff supervision. It further documents Routine procedures for prevention of missing residents and elopements or attempted elopements. 1. Using the MDS resident assessment schedule, all residents shall be reviewed for safety concerns and precautions. Residents at risk for elopement shall be identified and documented in the individual plan of care. 2. Unless otherwise identified in a plan of care, residents who are a risk for possible elopement shall be accompanied when leaving the facility grounds. The resident representative shall sign the resident out of the facility on the resident sign-out sheet. The facility presented an abatement plan to remove the immediacy on 9/19/24. During the validation of the abatement by the survey team on 9/23/24, multiple observations from 8AM-11AM, residents were observed inputting the door alarm to the smoking patio. V1 stated the facility attempted to change the door alarm code, but the system was reverting to the original code. V1 stated the door alarm company would be out later today to fix the alarm code issue and the facility will have a staff member sitting outside the smoker's patio door to ensure residents are not using the old code. At 3:07PM, the facility provided an updated abatement plan to reflect the door alarm was changed and working as of 9/23/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The Immediate Jeopardy that began on 08/17/24 was removed on 09/23/24, when the facility took the following actions to remove the immediacy. The facility provided an abatement plan that included the following: -On 8.17.24, at approximately 11:30 AM, staff observed the resident (R49) ambulating alone and assisted him to his w/c (wheelchair). At 1:30 PM staff were unable to locate the resident (R49) for lunch meal. The facility staff notified the Administrator (V1) and the Director of Nursing (V2) at 1:50 PM. V14, SSD, was designated person to record the sequence of events. At 1:55PM the regional nurse was notified by the Administrator (V1). The Regional Nurse notified the Director of clinical Operations at 1:57 PM. A 100% validation of residents being accounted for by completed head count was done at 1:58 PM per the facility policy. The interior building was searched and completed at approximately 2:00 PM. The Administrator (V1) notified the Police Department at 2:00 PM and a description was provided to the police. The police were notified of the R49's clothing as he was wearing a yellow polo shirt and PJ pants with slippers. The weather for the day was sunny with a temperature of approximately 83 degrees. Attempts were made to contact R49's spouse at 2:06 PM with no answer. A message was left to return the call. At 2:06 PM the County Sheriff was notified. R49's guardian was notified by phone and email at 2:15 PM. R49's physician was notified by phone at 2:15 PM. At 2:30 PM, V1 went to the area hospital to check to see if R49 was located there and later a call was made to follow-up. At 3:25 PM, the Administrator (V1) notified the State Survey Agency by email. At 551 PM V1 was notified by the County Sheriff Dispatch that the police have R49. R49 was transported to the hospital for evaluation per Administrator's (V1's) request. At 6:00 PM, R49's guardian was made aware R49 was with the police and was being transported to the ER for evaluation. At 6:15 PM, R49's was notified the resident (R49) was with the police and was being taken to the hospital for evaluation before returning to the facility. R49 returned to the facility with no injuries. The Elopement assessment was updated. The resident's (R49's) care plan was reviewed and updated. The resident (R49) was assisted to the memory care unit. The resident's (R49's) guardian is aware. On 8.17.24 The facility completed the following corrective actions: -The DON (V2) and the Administrator (V1) initiated staff re-education on the elopement policy and procedure. All staff was educated within 24 hrs., no staff worked without being educated. -The door alarm policy including door alarms should never be shut off or disengaged for any reason. -Emergency Ad Hoc QAPI meeting was held on 8.17.24 to discuss plan. -Medical Director notified at 2:15 PM on 8.17.24. -On 8.17.24 100 % of staff were educated within the first 12 hours. -8.17.24 Care plan for the resident (R49) involved has been revised to include resident specific interventions related to the resident's (R49's) risk for elopement. -8.17.24 100% Audit of the elopement risk assessment for all facility residents has been completed. -8.17.24 The facility residents that trigger at a risk for elopement have had their care plans reviewed and revised to include resident specific interventions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The Facility has a book in place with pictures and pertinent information of residents that trigger at risk for elopement. Staff can identify where the book is located. Door codes to be changed and staff educated that at no time are residents to be given the door alarm code. Staff are to input the code for anyone needing to exit the community. Ongoing The facility will provide ongoing education to all new employees and agency at the time of hire on the facility elopement policy and procedure and the door alarm policy. Education will be provided prior to a new employee being allowed to work in the facility as well as agency staff members. Concerns will be addressed immediately and discussed during the monthly QAPI (Quality Assurance Performance Improvement) Committee for resolution. On 9/19/24, at 2:00 PM, it was determined by the Illinois Department of Public Health that the facility was not in compliance. During the annual survey, a request was made to review the file of the Elopement that occurred as stated above. At 2:00 PM, a surveyor and her supervisor discussed an IJ violation with V1, Administrator and the V33, Regional Nurse, regarding the elopement. A template was emailed to the Administrator. The Administrator immediately initiated an abatement. The facility has individualized care plans for all residents with their specific interventions. Staff have been educated on the location on the elopement books and how to look at PCC (Point Click Care) and POC (Plan of Care) to ensure they know which residents are high risk and the interventions are in place. Staff members are and will continue to be in-serviced on new interventions put into place. All staff members were in serviced on 9/19 on how to locate interventions on Kardex and Care plans. R49 was placed on 1:1 in memory unit for the first 24 hours, then for 15-minute checks for 24 hours, 30-minute observations for 24 hours and no issues were identified upon return to facility. Staff continue to provide 1:1 supervision to resident while at Dialysis. He remains a resident on the Memory unit. What interventions implemented for R49 on the unit to ensure he doesn't attempt to elope from the unit? The resident remains on the secured courtyard unit where the door alarms sound if a resident attempts to leave without entering a security code. Doors are managed by an egress exiting. The exterior courtyard is secured by a gate that is alarmed. Following the initial incident, the immediate action included the above-mentioned 1:1 care and 24-hour checks. With the increased monitoring it was identified the resident was not exit seeking and the increased monitoring was removed, and is now managed in accordance with facility policy and procedure. -The Elopement Policy and Procedure was reviewed by V1, Administrator, V67, Regional Director of Operations, and V33, RN Regional Nurse, on 9/19/24 at 4:00 PM. -V33, Regional Nurse, V2, DON (Director of Nursing), and the V1, Administrator, immediately initiated education on the Elopement Policy and Procedure on 9/19/24 at 2:45 PM to all staff. All staff educated on location of Elopement books and identifiers of POC and PCC. No staff are to work without receiving education. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-V33, Regional Nurse, V2, DON, and the Administrator, V1, immediately initiated education on the Door alarm policy including door alarms should never be shut off or disengaged for any reason on 9/19/24 at 2:45 PM to all staff. -An Ad Hoc QAPI was completed including V40, Medical Director, to discuss the plan on 9/19/24 at 4:50 PM by V1, Administrator, and V33, RN Regional Nurse. -V40, Medical Director, was notified on 9/19/24 at 4:50 PM. -All residents have been reviewed and completed for risk of elopement on 9/19/24 by 4 PM. The assessments were completed by V14, Social Service Director (SSD), V24, MDS, and V68, Admission Coordinator (AMC). -All residents identified at high risk for elopement have current care plans that have been reviewed for appropriate interventions on 9/19/24 by 5 PM. The high risk for elopement care plans were reviewed and updated by V24, MDS. Ongoing: -All staff will be educated at the time of hire on the Elopement Policy as part of the orientation process by the V1, Administrator or designee. -All staff will be educated at the time of hire on the door alarm policy as part of the orientation process by the V1, Administrator or designee. -Elopement drill will be completed Quarterly. -V14, SSD, will randomly question 5 staff per week on what to do in the event there is an elopement. Date of Compliance: 9/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40701 Based on observation, interview, and record review, the Facility failed to provide timely toileting and incontinent care to prevent potential urinary tract infections (UTIs) for 3 of 3 residents (R145, R85, and R23) reviewed for incontinent care in the sample of 57. Findings include: 1. R145's Face Sheet, dated 9/18/2024, documents R145 was admitted to the facility on [DATE], with a diagnosis of Amyotrophic Lateral Sclerosis (ALS- also known as Lou Gehrigsdisease, is a fatal neurological disorder that causes nerve cells in the brain and spinal cord to die. This leads to muscle weakness, paralysis, and eventually the loss of the ability to breathe and control voluntary movements.) R145's Care Plan, dated 9/18/2024, documents R145 has bowel/bladder incontinence and prefers to use a bedpan while in bed, at night. Interventions include observe pattern of incontinence and initiate toileting schedule if indicated. Offer resident toilet at same time each day resident usually has bowel incontinence (after meals). Provide bedpan/besides commode. It also documents to check the resident every two hours and as required for incontinence-wash, rinse, and dry perineum. Goals include: R145 will have less than two episodes of incontinence per day through the review date. R145 will be continent during daytime through the review date. R145's Care Plan continues to document R145 has ADL (Activities of Daily Living) self-care performance deficit related to ALS, weakness, and osteoarthritis. R 145 is totally dependent on one staff member for toilet use. On 9/18/2024 at 9:39 AM, R145's call light was activated. V15, Certified Nursing Assistant/CNA entered R145's room. R145 told V15, CNA, she (R145) put her call light on because she asked for her bedpan an hour ago, was unsure who she asked, but they must have gotten busy and forgot. R145 stated she had an accident and needed cleaned up (provided incontinent care). On 9/18/2024 at 9:44 AM, V15 and V19, CNAs, performed incontinent care to R145. R145's adult brief was saturated with urine and a small amount of feces. V15 applied a new adult brief without drying R145's peri-area. On 9/18/2024 at 4:09 PM, V1, Administrator, and V8, Assistant Director of Nursing, stated they would expect staff performing incontinent care to pat dry the peri-area. V8 stated R145 should have been offered the bedpan when she requested it, prior to her having an incontinent episode. On 9/19/2024 at 9:34 AM, V2 stated they do not have a policy pertaining to incontinent care. V2 stated they expect staff to follow the best practice guidelines. 2. R85's Face Sheet, dated 9/19/2024, documents R85 has a diagnosis of Urinary Tract Infection (UTI) and Extended Spectrum Beta Lactamase Resistance (ESBL- enzymes that make bacteria resistant to many antibiotics, including penicillins, cephalosporins, and aztreonam. Infections caused by ESBL-producing bacteria can be difficult to treat and may require complex treatments). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F85's Care Plan, dated 8/30/2024, documents R85 has a urinary catheter. Inventions include catheter care every shift and as needed. It further documents R85 has bowel incontinence. Interventions include providing incontinent care after each incontinent episode. On 9/18/2024 at 3:00 PM, V23, Registered Nurse (RN), removed R85's adult brief. R85 had a small amount of feces in his adult brief. R85 had no dressing intact to his coccyx area (buttocks). On 9/18/2024 at 3:44 PM, V16, CNA, wet wash cloths in the bathroom sink. At no time did V16 apply any cleanser to the washcloths. V16 completed R85's catheter care and wiped the feces from R85's buttocks with the washcloths. V16 did not dry R85's peri-area or buttocks prior to applying a new adult brief. On 9/18/2024 at 4:09 PM, V1, Director of Nursing, and V8, Assistant Director of Nursing, stated staff are expected to use body wash or non-rinse peri cleanser, especially after an incontinent episode involving feces. V1 and V8 stated staff should pat the area dry. 49494 3. R23's Face Sheet, dated 9/24/24, documented R23 has diagnoses of COPD (Chronic Obstructive Pulmonary Disease), anxiety disorder, muscle wasting and atrophy, cognitive communication deficit, fracture of left femur, neuropathy, acute on chronic combined heart failure, iron deficiency anemia, sleep apnea, spinal stenosis, and depression. R23's MDS, dated [DATE], documented R23 is cognitively intact. R23's MDS documented R23 is frequently incontinent of urine and always incontinent of stool. On 9/17/24 at 9:25 AM, V9, CNA, was observed as she entered R23's room to answer the call light. R23 requested a bedpan. V9 was observed as she donned gloves, without the benefit of hand hygiene. V9 then removed R23's adult diaper. R23's diaper was completely saturated with urine, resulting in R23's linens and mattress to become saturated. R23's adult diaper also contained a large amount of feces. V9 then went into R23's restroom and returned with wet washcloths. V9 placed the wet washcloths on R23's side rail. V9 stated she applied hand soap from the restroom dispenser on the wet washcloths. V10, CNA, then entered to assist V9 with the incontinent care. V9 then proceed to cleanse R23's frontal region, without the benefit of hand hygiene or glove change. V9 cleansed R23's outer labia and inner thigh, but did not cleanse R23's inner labia region. V9 and V10 then repositioned R23 onto her right side and V9 cleansed R23's buttock region without cleansing R23's outer buttocks and hip region. V9 did not change gloves or perform hand hygiene prior to cleansing R23's buttocks. V9 and V10 then turned R23 onto her back, and V10 cleansed the remaining feces from R23's inner thighs. V9 and V10 did not rinse the soap from R23 at any time during the incontinent care, nor did they dry R23's skin. V9 and V10 then proceeded to change R23's bed linens while R23 was still in the bed, without performing hand hygiene and while wearing the same gloves that were worn during the incontinence care. V9 and V10 then removed their gloves and exited R23's room without the benefit of hand hygiene. On 9/17/24 at 12:10 PM, V9 stated she did use hand soap from R23's bathroom hand dispenser to cleanse R23's perineal region. V9 stated if she is supposed to use another type of soap during perineal care, no one has told her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/24 at 1:35 PM, V15, CNA, stated she would never use hand soap to wash a resident during peri-care. V15 stated she uses no rinse perineal cleanser when providing incontinent care for the residents. On 9/24/24 at 12:40 PM, V2, Director of Nursing, stated she would expect the CNAs to use no rinse perineal cleanser to clean residents during incontinent care. V2 stated the facility does not have an incontinence care policy and the facility follows best practices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on interview and record review, the facility failed to monitor and provide services for residents who verbalizes suicide threats for 1 of 1 resident (R31) reviewed for behavioral health services in the sample of 57. Findings include: R31's Face Sheet, dated 9/24/24, documented R31 has diagnoses of COPD (Chronic Obstructive Pulmonary Disease), benign prostatic hyperplasia, muscle weakness, hyperlipidemia, PTSD (post-traumatic stress disorder), depression, hypertension, obstructive and reflux uropathy, chronic migraine, and low back pain. R31's Minimum Data Set (MDS), dated [DATE], documented R31 is cognitively intact. R31's Care Plan Focus, date initiated on 11/13/23, documents (R31) has suffered a traumatic life event and declines services and intervention at this time. Related to PTSD. The Care Plan Focus, date initiated on 11/27/23, documents The resident has mood problems related to frustration of losing the independence and nursing home placement. (R31) will refuse care from staff at times. R31's Progress Note, authored by V17, Licensed Practical Nurse (LPN), dated 7/5/24 at 5:49 PM documented, patient stated he is at the point that he is done with doctors and insurance. Stated he could just take a gun and end it all. Writer told him that he shouldn't think like that, and patient stated he is dead serious. R31's Care Plan, print date of 9/17/24, does not address R31's voiced suicide threat that was made on 7/5/24. On 9/17/24 at 12:45 PM, V14, Social Service Director, stated she is not sure if R31 has ever voiced any suicide threats or not, since he was admitted to the facility. On 9/17/24 at 1:00 PM, V7, Licensed Practical Nurse/LPN for R31, stated she is not aware of any issues with R31 being suicidal. V7 stated R31 yells and curses frequently, and she re-directs him when he has these behaviors. On 9/17/24 at 1:05 PM V9, CNA, stated R31 is mad every day, curses, and screams, but she has never heard of him making any suicide threats. On 9/17/24 at 1:10 PM, V10, CNA, stated she has never heard anything about R31 threatening suicide in the past while residing at the facility. On 9/17/24 at 1:31 PM V17, LPN, stated she was R31's nurse when he made the suicide threat on 7/5/24. R31 stated she thinks she called R31's doctor but not sure, and she may not have charted it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/24 at 2:10 PM V20, R31's Physician, stated he was not notified of R31's suicide threat that was made on 7/5/24. V20 stated he checked R31's medical records and there is no documentation regarding R31 making a suicide threat. On 9/17/24 at 4:52 PM, V20 stated if he would have been notified of R31's threat of suicide that was made on 7/5/24, he would have made an acute visit to see R31, and then would determine if R31 needed to go to the ER (emergency room) or not, that he would have had the facility staff search R31's room for dangerous objects, and he would have put R31 on close monitoring until he was transferred, or no longer a suicide threat. On 9/18/24 at 9:37 AM, V21, CNA, stated she is not aware of any recent suicide threats by R31, stated he made one a few months ago when she was working in management, but she does not know what the facility did about it. On 9/18/24 at 4:20 PM, V1,Administrator, stated R31 is going to the hospital because he threatened suicide this afternoon. V1 stated she would have to look at R31's chart to see if R31 has ever voiced any suicide threats previously. R31's Progress Note, dated 9/18/24 at 3:55 PM, documented, (Administrator,V1) came to this nurse and reported that resident needed to be sent out related to stating he was talking about suicide. (CNA, V22) confirmed that he said this. Resident was immediately put on one on one. R31's Progress Note, dated 9/18/24 at 3:57 pm, documented, called Dr. (V20's) office and reported that resident is going to be sent to local hospital ER (emergency room) related to suicidal. R31's Progress Note, dated 9/18/24 at 4:09 PM, documented, 911 called for resident to be picked up and taken to local hospital ER for suicide threats. On 9/23/24 at 10:17 AM, V33, Regional Director, stated when R31 voiced a suicidal threat on 7/5/24, she would have expected R31's nurse to call the Administrator and R31's doctor, update R31's care plan regarding the suicide threat, and have staff stay with R31 to make sure R31 was safe. On 9/23/24 at 10:31 AM, V1, Administrator, stated she was notified of R31's suicide threat that was made on 7/5/24. V1 stated she is not going to speculate on what the facility staff did for R31 after R31 made the suicidal threat on 7/5/24. On 9/23/24 at 10:35 AM, V33, Regional Director, presented R31's care plan and stated R31's care plan does address R31 is a risk to self. This care plan, with a revision date of 9/19/24, documented monitor/record/report to MD (Medical Doctor) prn (as needed) risk for harming self or harming others. This surveyor presented R31's care plan with a print date of 9/17/24 to V33. R31's care plan, print date of 9/17/24, documented monitor/record/report to MD prn risk for harming others. V33 agreed R31's care plan did not address R31 being a harm to himself until the revision date of 9/19/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Suicide Threats policy, dated 2/21, documented 1. If a resident makes a suicidal threat, stay with the resident, and immediately notify the nurse. 2. The nurse will assess the resident, notify the DON (Director of Nursing)/designee and medical practitioner and establish a plan of care. 3. As indicated, a psychiatric consultation or transfer for emergency psychiatric evaluation may be initiated. 4. If the resident remains in the facility, all nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the resident's behavior immediately. 5. Staff will document the resident's mood and behavior and update care plans accordingly. 6. The resident's environment will be evaluated, and potentially dangerous items will be removed. (i.e., sharp objects, belts, trash bags, etc.) 7. The IDT (Interdisciplinary Team) will review the resident behaviors and documentation to determine if there is a need to revise the plan of care. Practitioner and resident representative will be notified of any changes in the plan of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview, observation, and record review, the facility failed to dispose of an open multi-dose vial of Insulin after 30 days, failed to dispose of an expired bottle of stock medication, and failed to date an open vial of Tuberculin that is used by all staff and residents. This failure has the potential to affect all 93 residents in the facility. The Findings include: On [DATE] at 9:35 AM, the facility's Medication Room was checked with V7, Licensed Practical Nurse (LPN). There was one Medication Refrigerator checked with a Tuberculin (TB) Vial in the box, with a date of delivery of [DATE], was open and did not have an open date. A Lantus Insulin Pen 100Units/Milliliter (ML)/3ML was seen sitting in the fridge, with no resident name or date written on it. V7 stated, There is usually a resident label on the pen, or it should be in a plastic bag from the pharmacy with a resident name on it. On [DATE] at 9:40 AM, V7, LPN, stated, We use that TB vial for all staff and residents when needed. If I found it without a date opened, I would discard it. On [DATE] at 9:50 AM, the Medication Cart behind the nurse's desk was checked with a bottle of Oyster Shell Calcium 500 Milligram (MG) capsules with the bottle appearing mostly full, and showing an expiration date of ,d+[DATE]. A vial of Humalog Insulin 10 ML was seen in the original box with a date opened of [DATE], past the 30-days since opened. On [DATE] at 9:32 AM, V7, LPN, stated, Our Medical Records person orders the Over the Counter (OTC) medications and when they come in, she brings them to the nurse, and they go through it and will check expirations. We all check expirations on the medications every month. On [DATE] at 9:45 AM, V8, Assistant Director of Nursing (ADON), stated, The nurses should be putting a date on all medication vials when opened, and the vial should be thrown away after 30-days. All medications in the carts and the med room should be checked for expirations every month. The Facility provided Medication Storage Parameters - Medications requiring discarding before listed expiration date, undated, documents, Insulin Vials: All vials should be dated with beyond use date to discard 28 days after opening. Humulin products can be used up to 31 days after opening. Multi-Dose vials for injection (not insulin): A beyond use date of unused portion to discard is placed 28 days after opening or in accordance with manufacturer's recommendation. Tubersol (Tuberculin): Beyond use date for 30 days after opening. The Facility's Drug Labeling Policy, dated ,d+[DATE], documents, A. The label of each individual container shall clearly indicate the resident's full name, physician's name, prescription number, name and strength of drug, directions for administration, date of issue, the initials of the pharmacist filling the prescription, and the amount of medication contained in each individual prescription. D. Medication having no labels should be destroyed in accordance with Federal and State laws. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility's Storage and Return of Drugs, dated ,d+[DATE], documents, B. Residents' medications shall be properly labeled and stored at or near the nurse's station in a locked cabinet. E. Multi-Dose vials and pens shall be stored and dated per the manufacturers guidance. The Long-Term Care Facility Application for Medicare and Medicaid, CMS 671, dated [DATE], documents the total number of residents in the facility was 93.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview, observation, and record review, the facility failed to perform proper hand hygiene and/or the changing of gloves while plating food, failed to date food when opened and/or cooked, and failed to check and maintain the temperatures of the food, including all diets (regular diets, special diets, and pureed foods) prior to serving the residents to prevent contamination and foodborne illness. These failures have the potential to affect all 93 residents living in the facility. The findings include: On [DATE] at 9:15 AM, during the initial tour of the kitchen, V11, Interim Dietary Manager (DM), stated, I can't find the fridge/freezer temperature logs. It's a mess, I'll look for them. Upon assessment of the kitchen, a bag of bacon was seen in the refrigerator and was dated [DATE] as opened, but the bag was open and not sealed. A gallon of chocolate milk, half full, was seen with no open date and an expiration date of [DATE]. A box of cucumbers was seen in the walk-in refrigerator sitting on the floor of the refrigerator. A frozen bag of ground meat was sitting in the sink with hot running water pouring over the meat. When asked what that was, V12, Cook, stated it was for the turkey sloppy joe sandwich for lunch today. V11 provided the temperature logs with the last food temperatures taken on [DATE] lunch. On [DATE] from 11:50 AM until 1:15 PM, the Kitchen observation for Lunch was completed with V12, Cook. V12 was seen starting to plate food with two pureed scoops of chicken already on plates. When asked about checking the temperatures of the food, V12 stated she took all the temps when the food came out of the oven. When reviewing the temperature log, there were no temperatures written down for lunch. When asked to temp the food, V12 obtained a digital thermometer and ran it under water, then stuck it in the pureed food. The thermometer was not functioning and had an error code on it. V12 asked V11, Interim Dietary Manager (DM), for another thermometer, with V11 bringing a new thermometer from the back and stated that this one is brand new, so it doesn't need to be calibrated. V12 stated she is supposed to calibrate the thermometers every day, but has not done it today yet. V12 used the new thermometer to test the food. The temperature of pureed peas read 159 degrees Fahrenheit (F). V12 took the peas to the electric steamer to warm it up, and after warming, V12 rechecked the temperature which was now reading 163 degrees F. and was placed in the food line to plate. On [DATE] during lunch observation from 11:50 AM until 1:15 PM, V12 was seen leaving the serving line numerous times with her gloves on, going to several places in the kitchen gathering utensils, lids, and other supplies, then going back to the serving line to continue to plate the food. V12 used the same gloves throughout the lunch, including serving food, gathering supplies, going to food steamer and back to the food line to serve food, with no changing of gloves and no hand hygiene performed. V12 was seen with a surgical mask only covering her mouth and not her nose. V12's hairnet was not covering all her hair, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	with sides and back hair hanging out of net. V11's hair was also hanging out of her hairnet, both sides and back. V13, Dietary Aide (DA), was seen with a full beard and no hairnet on while working with the food. V13 was seen working the fryer and assisting to plate specialty plates. V13 was seen wearing the same pair of gloves as he worked several places around the kitchen and handling multiple items. There was no hand hygiene seen done during the entire lunch service. On [DATE] at 12:25 PM, while plating food, V12 bumped a tray of plastic bowls that was sitting on top of an uncovered large container of soup, and the tray fell into the soup. V12 pulled the tray and bowls out of the soup and placed it on the bottom shelf of a plastic cart. V12 picked up another tray of bowls on a bottom shelf in the kitchen and placed it on top of the container of uncovered soup again. Once the tray of bowels was removed from the bottom shelf, the shelf appeared to be soiled and very dirty. On [DATE] at 12:25 PM, the hamburgers were rechecked with a temperature reading of 145 degrees F. On [DATE] at 12:30 PM, V13 opened a bag of buns and used his hands with his soiled gloves to get the buns out, placed a burger on the bun, got a slice of cheese from the fridge, and placed it on the burger, then microwaved the sandwich, bun, and all. V13 did not check the temperature prior to putting fries on the plate and serving it to a resident. V12 was also seen grabbing buns multiple of times from the bag using her soiled gloves and placing the buns on a plate. On [DATE] at 12:40 PM, there were no temperatures documented for lunch on the temperature log sheet. There were no refrigerator or freezer temperatures dated [DATE] on the log. On [DATE] at 12:50 PM, upon further inspection of the kitchen, there was a bag of frozen curly fries that were seen open in the freezer with no date and the bag wide open. The dry stock supplies had five prune juice boxes (1.36L each) that had expiration date of [DATE]. There was a package of buns on the bread shelf with no date and was not closed, an open country white deli bread that was open with no date, an open loaf of white bread that was tore open and not sealed or dated, and an open bag of bagels seen on top of bread shelf that had five bagels with mold on each of them. On [DATE] at 1:10 PM, when asked for alcohol wipes to wipe off the thermometers, V11 stated they are out, and she will have to get some from the nursing department. When asked where they are washing their hands, V13 pointed to a sink, and stated they use that sink with soap and water. When asked how they dry their hands after washing their hands, V13 looked and there were no towels available, so he walked around the kitchen and came back with a couple of hand towels, and stated that was housekeeping's job, and they must have run out of them. On [DATE] at 9:00 AM, upon walking into the kitchen, there were no towels seen above the sink to dry your hands, once washed. V13 was seen putting on a beard mask after this surveyor entered the kitchen. V11's hair was seen hanging out of her hair net, both her sides and the back, while she was making cheese sandwiches. The Facility's Grievance Form, dated [DATE], documents, Description: Food arrives cold at every meal. Example got chicken and rice soup it came to me ice cold. Investigation: Food covers being used and checked temps. Summary/Findings: Found insulated cover not effective. Action Taken: New insulated covers ordered and put into place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility's Grievance Form, dated [DATE], documents, Description: During rounds, new admission surveys several residents on 200-hall had concerns with cold meals. No specific mealtime said it's the majority of them. They don't like to ask the CNAs to reheat due to that causes others to have even colder meals if CNAs have to stop. Investigation: Checked that foods are being temped and delivered promptly. Findings: New domes not being used and plate warmer not working. Action Taken: New plate warmer received and in use. Food saran wrapped during interim. On [DATE] at 12:55 PM, V11, Interim DM, stated, I am not certified yet, but we are covered by the (Company's) Certified Dietary Manager (CDM) Certificate. I don't have any policies back here; we would follow the facility's policies. On [DATE] at 10:00, V1, Administrator, stated, I would expect all of the kitchen staff to do proper hand washing and glove changes, when necessary, to wear hairnets with all hair tucked inside the hairnet, including any male with a beard. I would expect the cook and/or manager to check the food temperatures when coming out of oven/stove, prior to serving to resident, and throughout the serving time to maintain food at appropriate temperatures, and to thaw out food the proper ways. I would expect all expired foods to be thrown out, all food items should be sealed while storing, and all opened food items should have an open date. We will start some education immediately because this is not acceptable. The Facility's Food Storage (Dry, Refrigerated, and Frozen) Policy, undated, documents, 1. General storage guidelines to be followed: a) All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded. c) Discard food that has passed the expiration date, and discard food that has been prepared in the facility after seven days of storing under proper refrigeration. 2. Refrigerated storage guidelines to be followed: b) Conduct random temperature checks of food items. 3. Frozen storage guidelines to be followed: b) Check freezer temperature regularly. 4. Dry storage guidelines to be followed: c) Store dry food on shelves two inches away from walls to allow ventilation, six inches off the floor to allow for proper sanitation, and 18 inches from the ceiling to ensure fire safety. The Facility's Hair Restraints, undated, documents, Hair restraints shall be worn by all Dining Services staff when in food production, dishwashing areas or when serving food from the steam table. 1. Staff shall wear hair restraints in all food production, dishwashing and when serving food from steam or cold table areas. 2. Hair restraints, hats, and/or beard guards shall be used to prevent hair from contacting exposed food. Facial hair is discouraged. Any facial hair that is longer than the eyebrow shall require coverage with a beard guard in the production and dishwashing areas. 3. All those delivering plated food to residents will pull all long hair back and/or wear an appropriate hat while serving. Hairnets are discouraged due to the institutional look that may interfere with the desired dining room atmosphere. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility's Hand Washing and Glove Usage, undated, documents, All employees will use proper hand washing procedures and glove usage in accordance with State and Federal Sanitation Guidelines. 3. All employees will wash hands upon entering the kitchen from any other location, after breaks, and between all tasks. Hand washing should occur at a minimum of every hour. 4. Employees will wash hands before and after handling foods, after touching any part of the uniform, face, or hair, and before and after working with an individual resident. 5. Gloves are to be used whenever direct food contact is requires. 6. Hands are washed before donning gloves and after removing gloves. 7. Gloves are changed any time hand washing would be required. This includes when leaving the kitchen for a break or go to another location in the building; after handling potentially hazardous raw food; or if the gloves become contaminated by touching the face, hair, uniform, or other non-food contact surface, such as door handles and equipment. 8. Staff should be reminded that gloves become contaminated just as hands do and should be changed often. When in doubt, remove gloves and wash hands again. 9. When gloves must be changed, they are removed, hand washing procedure is followed, and a new pair of gloves is applied. Gloves are never placed on dirty hands; the procedure is always wash, glove, remove, rewash, and re-glove. The Facility's Monitoring Food Temperatures for Meal Service, undated, documents Food temperatures will be monitored daily to prevent food borne illness and ensure foods are served at palatable temperatures. 1. Prior to serving a meal, food temperatures will be taken and documented for all hot and cold foods to ensure proper serving temperatures. Any food item not found at the correct holding/serving temperature will not be served but will undergo the appropriate corrective action listed below. 2. The temperature for each food item will be recorded on the Food Temperature Log. Foods that required a corrective action (such as reheating) will have the new temperature recorded with a circle around it next to the original temperature. 3. Proper procedures are followed to ensure that food temperatures are accurately and safely obtained according to safe food handling practices. These procedures include the following steps: a) A properly functioning and calibrated thermometer will be used when takin temperatures. b) Thermometers are washed, rinsed, sanitized before, and after each meal use. An alcohol swab may be used to sanitize between uses while taking temperatures during the same meal or if contamination of the thermometer occurs. The Long-Term Care Facility Application for Medicare and Medicaid, CMS 671, dated [DATE], documents the total number of residents in the facility was 93.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 33205 Based on interview and record review, the facility failed to ensure their facility assessment was updated to include all necessary components per the current standards of practice. This failure has the potential to affect all 93 residents residing in the facility. Findings include: The Facility Assessment, dated 7/11/22 - 7/10/23, did not include the following in the plan: identifying resources provide necessary care and services the residents require during both day-to-day operations and emergencies (including nights and weekends) and emergencies; evaluation of the overall number of facility staff needed to ensure sufficient number of qualified staff are available to meet each resident's needs as identified through resident assessments and care plans; pertinent information about the resident population the facility serves may include race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, preferred language, health literacy or other factors that affect access to care and health outcomes related to health equity; physical environment, equipment (medical and non-medical), assisted technology, individual communication devices, or other material resources that are needed to provide the required care and services to residents; evaluations of the facility's training program to ensure any training needs are met for all new and existing staff including managers, nursing and other direct care staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. The assessment did not include an evaluation of applicable policies and procedures, facility based and community-based risk assessment, utilizing an all-hazards approach that evaluates the facility's ability to maintain continuity of operations and its ability to secure required supplies and resources during an emergency or natural disaster, and contingency plan for events or an all-hazards approach. On 09/25/24 at 9:10 AM, V1, Administrator, stated she would have to look to see if she had an updated Facility Assessment for 2024. On 09/25/24 at 10:00 AM, V33, Regional Direction, stated V1 was suspended for an abuse allegation, and they do not have another facility assessment for 2024. On 9/25/24 at 12:41, V33 stated they do not have a policy on facility assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44556 Based on observation, interview, and record review, the facility failed to ensure staff donned/doffed Personal Protective Equipment (PPE) on the COVID-19 positive hallway, in a manner to prevent cross contamination; failed to ensure residents were not exposed to staff exhibiting symptoms of COVID-19; failed to implement transmission-based precautions for residents that were COVID-19 positive who were mobile throughout the unit including the hallway and dining/day areas; failed to ensure COVID negative residents were not exposed to COVID positive residents; failed to cohort positive COVID-19 residents together and instead cohorted positive and negatives together; failed to ensure signage posted indicating a positive COVID status; failed to offer/educate COVID vaccinations for residents and staff since 2022; and failed to have a system in place to track, trend and test residents and staff during a COVID-19 outbreak. This failure has the potential to affect all 23 residents residing on the 100 hall of the facility. Findings include: 1. On [DATE] at 8:45 AM, upon entering the facility, there was no signage observed indicating the facility was in a COVID-19 outbreak. On [DATE] at 9:00 AM, V46, Courtyard Coordinator, V70, Certified Nursing Assistant (CNA), and V71, CNA, were observed on the Covid positive unit wearing only an N95 mask. R82 was observed walking up and down the hall with no PPE (mask) on. (R82 was later identified as COVID positive). V46, V70, and V71 failed to wear eye protection around a COVID positive resident. On [DATE] at 12:38 PM, R19, who was COVID positive, was observed sitting at the same table during the afternoon meal as R61, who was COVID negative. (R19 was later identified as COVID positive and R61 later identified as negative for COVID) On [DATE] at 12:20 PM, V46, Courtyard Coordinator, V70, CNA, and V71, CNA, were observed wearing only their N95 mask, without any eye protection. R7, R49, R70, and R82 (who were all later identified as COVID positive by V9, CNA) were observed not having on any type of PPE. R49, who was COVID positive, did not have mask on, was observed sitting at the dining room table during the afternoon meal with R66, who was COVID negative. No staff were observed trying to encourage residents to put on a face mask. On [DATE] at 2:35 PM, V9, CNA, walked this surveyor down the hall and pointed out who was COVID positive and who was negative. V9 identified the following: R77 who was COVID positive was in the room with R37 who was COVID negative; R82 who is in a room by himself was positive; R19 who is COVID positive and in a room with R66 who is negative; R87 was COVID positive and in a room with R10 who was negative; R50 was COVID negative and in a room with R73 who was COVID positive; R61 who was negative was in a room with R7 who was positive for COVID; R70 who was COVID positive was in a room with R21 who was initially negative but became positive, placed on hospice and later expired; R67 who was negative was in a room with R47 who was COVID positive; and R49 who was COVID positive was in a room with R60 who was COVID negative. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 - Many	On [DATE] at 2:22 PM, V34, Licensed Practical Nurse (LPN), and V35, LPN, were observed to have on only an N95 mask without eye protection on the Covid positive unit. On [DATE] at 08:35 AM, V25, CNA, observed to be wearing N95 mask without eye protection on the Covid positive unit. On [DATE] at 09:23 AM, V46, Courtyard Coordinator, was observed wearing a gown and N95 mask. No eye protection was observed. V46 stated when going into a resident's room who is COVID positive, staff should wear a gown, N95, goggles or face shield, and gloves, and it should be changed after each person who is COVID positive. On [DATE] at 09:50 AM, V25, CNA, stated staff should be wearing gown, goggles, gloves, and N95 mask when going into a room with a COVID positive resident. V25 said they try to keep the covid positive residents in their rooms, but it's hard because they like to wander. She said she didn't understand why they didn't move any of the resident's when they were covid positive. On [DATE] at 04:22 AM, V63, CNA, stated the facility did not move any of the residents on the unit during the COVID outbreak, and they kept the positives with the negatives. V63 said she questioned the nurses on the unit as to why negative and positive residents stayed together because there were residents on the unit that no longer needed to be and could have been moved out to the other halls. On [DATE] at 2:38 PM, V50, R37's Daughter, was seen walking into the COVID positive unit with no Personal Protective Equipment (PPE) on, walked down the hall and into R37's room, and then was seen exiting the hall and out the facility's front door. At no time was any PPE seen put on, or any hand hygiene done. On [DATE] at 2:29 PM, V9, CNA, was observed to be only wearing an N95 mask on the COVID unit. She said R77, who is currently out at the hospital, is now COVID positive. She said the man (R21) who just passed was the worst COVID positive one she seen, but she said he also had pneumonia. 2.R21's Admission Record, with a print date of [DATE], documented R21 has diagnoses of but not limited to Alzheimer's disease, Pneumonia, unspecified organism, and personal history of COVID-19 R21's Minimum Data Set (MDS), dated [DATE], documented R21 is severely cognitively impaired, was dependent on staff for all of his activities of daily living (ADL), and was always incontinent of bowel and bladder. R21's Physician's Orders, dated [DATE] at 5:49 PM, documented COVID- May complete antigen testing to rule out COVID 19. R21's Physician's Orders, dated [DATE] at 1:47 PM, documented COVID- vital signs (VS) and oxygen saturation (O2) every 4 hours for 14 days every shift. R21's current Physician's Orders were reviewed and documented R21 had COVID- Resident in isolation related to (r/t) active Covid positive. All services to be provided in resident room including therapy, activities, meals, and nursing services every shift for 14 Days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 - Many	R21's Progress Notes, dated [DATE] at 7:52 PM, documented, Condition poor, head of bed (HOB) elevated, rattling respirations, oxygen (O2) at 5 Liters (L)/mask, skin warm and dry (w/d). Keeping eyes closed, arms flaccid. Difficulty swallowing. Depends on staff for all ADL'S. No mottling noted at this time. Family at bedside. Comfort care. R21's Progress Notes, dated [DATE] at 1:12 PM, documented, resident continues to decline, and family is at bedside. Resident is not swallowing anything. HOB (Head of bed) elevated. Continuous 5L O2. Resident appears to be resting without discomfort. Comfort measures. R21's Progress Notes, dated [DATE] at 9:26 PM, documented, remains on antibiotic (ABT) for pneumonia, no adverse reaction noted. HOB elevated, O2 at 5L/mask. Void x1 incontinent. No by mouth (po) intake. Condition remains poor. Family at bedside. R21's Progress Notes, dated [DATE] 01:57 AM, documented, (R21) continues PO ABT for pneumonia. No adverse reactions noted. Resident continues to decline in condition. Daughter has been by his side a good portion of the night. Continues 5L per nasal canula (NC). Resident is not restless or showing signs of pain, although he does have apneic breathing. Resident using as needed (PRN) Ativan. R21's Progress Notes, dated [DATE] at 10:49 AM, documented, Social Services talked to family today. They were hesitant about deciding to set up hospice services. Social Services provided education to family and what hospice offers. R21's Progress Notes, dated [DATE] at 1:51 PM, documented, Family came to Social Services and asked her to send referrals to all companies to try and get R21 admitted immediately to hospice for his comfort. Social Services sent one referral to three different hospice companies, and whichever is able to admit first will be the accepted company. Social Services will continue to follow and see if we can get him admitted today. R21's Physician's Orders, dated [DATE] at 5:40 PM, documented R21 was admitted to hospice with a primary diagnosis of Covid 19 and secondary diagnosis of Cerebral Atherosclerosis. R21's Progress Notes, dated [DATE] at 6:06 PM, documented, Resident started on hospice services; resident doing poorly with family still at bedside. R21's Progress Notes, dated [DATE] at 11:20 AM, documented, (R21) continues on Hospice, resident is modeling from the feet, O2 at 85% on 3L O2 via NC, no breakthrough pain or discomfort noted, resident's pulse is greater than (>)110, he has spiked a fever of 101.4, hospice nurse in to see resident and informed her of his condition. Writer let hospice know the family is declining the Tylenol suppository at this time (for fever) and declining the Hyoscyamine as well. They would rather we leave him alone. R21's Progress Notes, dated [DATE] 12:25 PM, documented, (R21) passed away at 12:25 PM with family and staff at bedside, very comfortably. Apical pulse auscultated for 1 minute, no pulse found. Hospice called and made aware. Resident's body will go to the Funeral Home of family's choice. R21's death certificate, date of death [DATE], was reviewed and documented cause of death Part I. a. 2019-N COVID Acute Respiratory Disease, b. Alzheimer's Disease, C. Dementia, Severe, without behavioral disturbances. Part II. Pneumonia, unspecified organism. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 - Many	[DATE] at 1:49 PM V41, R21's physician was contacted about R21. V41 stated he wasn't aware R21 was in a room with a COVID positive resident prior to R21 getting COVID, and no he didn't think he would cohort residents who are COVID positive with residents who are negative. V41 said it would be hard to say if R21's COVID positive status was one of the reasons R21 was placed on hospice and then later passed away. He said R21 had been ill a long time with aspiration pneumonia off and on. 3. On [DATE] at 08:54 AM, R19 was slumped over in his wheelchair and was taken to his room to be laid down. V21, CNA, and V25, CNA, took R19 into his room, with no hand hygiene being done prior and they only had on a gown and N95 mask, no gloves or eye protection were noted. At 8:57PM, V21, CNA, came out of R19's room after lying him down with the same gown on, and then went into the shower room wearing the same gown. At 09:00 AM, V25, CNA, came out of R19's room still wearing the same gown and mask, got a walker from across the hall, and went back into R19's room. At 09:02 AM, V25 came out of R19's room still wearing the same gown, and went over into the dining area, then went into the shower room with the same gown. 4.On [DATE] at 08:53 AM, V43, LPN, stated she just had COVID and just came back to work last week. V43 said she has heard other staff have been positive for COVID, but she doesn't know who they are. She said they don't report to her when someone is positive, so she has no idea. On [DATE] at 9:00 AM, V46, Courtyard Coordinator, stated they don't test staff unless they have COVID symptoms. On [DATE] at 2:00 PM, when asked how many residents in the facility are positive with COVID-19, V2, DON, stated, I really don't know. There may have been some come off the list already. When asked who and when they are testing for COVID-19, V33, Regional Director, stated, Per our policy, we test after our first positive and after day five and day seven, and once we have another positive, we start over again until we are negative. We will put a list of residents who are positive with COVID and who have been tested . On [DATE] at 8:30 AM, V2, DON, stated, Just to let you know, I am already working on the POC (Plan of Correction) and working on getting everything updated for September. On [DATE] at 8:48 AM, V23, Registered Nurse (RN), stated she was COVID positive on [DATE]. V23 stated she worked the 100-Unit (later identified as the COVID locked unit) on [DATE], and was supposed to work on [DATE], but she was not feeling well, so tested for COVID, and noted to be positive. V23 stated she was offered the COVID vaccination in 2021 and 2022, but declined, and has not been offered since. V23 stated she thought they handed out some COVID education papers at one time. V23 stated she usually works on the 100-Unit unless she is extra or the community nurse, then helps everywhere. V23 stated everyone is supposed to wear N-95 mask upon walking through the 100-unit doors and full PPE, gown, gloves, face shield, mask upon walking into a resident room. V23 stated she sees visitors coming and going in and out of the 100-hall doors without anything on, no mask or anything. V23 stated she tries to educate them, but is usually told I don't care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 - Many	On [DATE] 8:51 AM, V27, Certified Nursing Assistant (CNA), stated she just started at the facility on [DATE] after just getting over COVID 2 weeks prior from a different facility. V27 stated she is aware of some staff getting COVID, but is unsure of names. V27 stated she has never been offered the COVID vaccination at this facility and has not had any kind of COVID education offered. V27 stated she mostly works the 200-hall, but has worked the 100-hall before. V27 stated all she was told she had to wear in the 100-Unit was the N-95 mask, and she has never been told she had to wear gown, gloves, or face shield, and she was unaware that she was supposed to. On [DATE] at 9:03 AM, V44, Dietary Aide, stated he was tested two days ago and he tested himself due to the high risk in the facility. V44 stated he is aware of one person in laundry that was COVID positive a month or so ago, and that V13 was also positive. V44 stated he was vaccinated in 2021 and 2022 with boosters, and he went to the local health clinic to get them. V44 believes he did receive COVID information from the facility. V44 stated he only works in the kitchen. V44 stated he uses a mask, gloves, and washes his hands, but does not wear gown or eye protection. On [DATE] at 9:06 AM, V11, Dietary Manager, stated she was tested about one and half weeks ago, and she tested negative. V11 stated she had two employees, V48, Dietary Aide, and V13, Dietary Aide. V11 stated she has not been offered the COVID vaccination or COVID education from the facility. V11 stated they don't have to wear PPE in the kitchen, but if staff are going into the 100-unit, they should be wearing gown, gloves, face shield, and mask. V11 stated her staff go into the unit two to three times a day to deliver meals. On [DATE] at 9:12 AM, V45, LPN, stated she tested last week on Monday and Thursday and was negative. V45 stated she knows (V49, CNA), tested positive last week, and is now off work. V45 stated she was vaccinated, but it was at other places and not at this facility, has not been offered vaccination or education at facility. V45 stated she works each floor because she is the Restorative Nurse. V45 stated if any staff is going into the 100-Unit, they are supposed to wear a N-95, a gown, gloves, and a face shield, because those residents are walking around everywhere. On [DATE] at 10:35 AM, V48, Cook/Maintenance, stated he was PT (part time) Maintenance and PT [NAME] at the facility. V48 stated on either [DATE] or [DATE], he came into work and wasn't feeling well, and told his mother (V1), and she advised him to test for COVID, and he tested positive. V48 stated V13, DA/Dietary Aide, also tested positive. V48 stated he was not offered the COVID vaccination, and his mom (V1) told him there is a COVID packet of information he could have if he wanted it, and he declined. V48 stated he is a [NAME] and cooks the food for all residents. V48 stated the Dietary Aide typically takes the food to the halls, and he will only do it if someone requests a special tray that he will make up and deliver to that resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 - Many	On [DATE] at 3:00 PM, V47, Housekeeper, was seen coming out of the 100-hall pushing her housekeeper cart. When asked about the cart, V47 stated she uses the same cart throughout the facility. When asked about her process for coming out of the COVID hall (100-hall), V47 stated she takes her cart and cleans everywhere that needs to be cleaned, halls, resident rooms, restrooms, ect., and when she gets done with the 100-hall, she will take the cart to the housekeeping closet, on the 400-hall, and will put her soiled mop head and rags in a barrel and then dump the mop water and trash. V47 stated the Laundry Department will pick up the soiled mop heads and wash them. V47's housekeeping cart had a large trash container on side of cart that appeared full of trash and not covered. When asked, V47 stated that was from the 100-hall. V47 stated they do have other housekeeping carts in the facility, but was never aware to use one specific cart for the COVID Unit/Isolation rooms. R47 was seen dumping the contaminated mop water from the 100-hall into a large sink in the closet with no gloves or other PPE on. On [DATE] at 10:25 AM, V2, Director of Nursing (DON), stated, Both me and (V8, Assistant Director of Nursing/ADON) are certified Infection Preventionist (IP) for this facility, but (V8) does most of the work with it. V2 is the facility's IP with a Certification on file, dated [DATE]. V8 is also the facility's IP with a Certification on file, dated [DATE]. On [DATE] at 2:15 PM, after being asked for a list of residents and staff who are positive for COVID-19, V1, Administrator, and V33, Regional Director, provided a LTC (Long Term Care) Respiratory Surveillance Line List, handwritten, and dated [DATE]. This list documents R78 was the only resident, along with two staff members, who were COVID Positive. R78 tested positive on [DATE], V6, LPN, tested positive on [DATE], and V42, Housekeeper, tested positive on [DATE]. On [DATE] at 2:15 PM, V1 and V33 provided a LTC (Long Term Care) Respiratory Surveillance Line List, dated [DATE]. This list has seven residents listed who have tested positive with COVID-19, ranging in dates from [DATE] to [DATE]. On [DATE] at 9:00 AM, V1 and V33 also provided a LTC (Long Term Care) Respiratory Surveillance Line List, dated [DATE]. This list has one staff member and one resident who tested positive for COVID. On [DATE] at 9:05 AM, V33 also provided a handwritten list of residents who were tested , including the dates tested . This list documents the first positive COVID was on [DATE] was R82, which is different than previous list given. There is nothing documented in the Infection Surveillance log since the end of August (31st), including all residents who currently are COVID-19 Positive. V2 stated, With all the DON duties and trying to train (V8) to do Infection Control, I have not had time to do anything with it. On [DATE] at 3:00 PM, when asked about offering the residents and staff the COVID vaccination and/or booster, V2, DON, stated, After it was mandated in 2022, I don't recall doing anything after that, but I also was not here in 2022. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 - Many	On [DATE] at 8:40 AM, V1, Administrator, stated I would expect all staff to maintain all COVID precautions, including tracking, testing, and offering education and vaccinations as needed' V1, Administrator, stated, I would expect the Infection Preventionist to keep up with the infection surveillance daily, weekly, and monthly to make sure residents are on the correct antibiotic and treatments. On [DATE] at 2:04 PM, when asked what his expectations are of the facility vaccinating the residents, V40, Medical Director, stated, All residents in the facility should definitely be vaccinated against COVID and the Influenza. This should have already been started in September. I feel that any resident who gets COVID has the potential for serious harm and/or death. The vaccination, if administered, would improve, or at least diminish, the harm and severity of the disease. I would expect the facility to keep up with the vaccinations, especially COVID and Influenza, and I will be working with them to get this done. The Facility's SARS-CoV-2 Infection Policy, dated [DATE], documents, HCP (Health Care Providers), Residents, and Visitors should be offered resources and counseled about the importance of receiving the COVID-19 vaccine. Additionally encourage everyone to remain up to date with all recommended COVID-19 vaccine doses. Ensure everyone is aware of recommended IPC (Infection Prevention Control) practices in the facility. Post visual alerts at the entrance and in strategic places. These alerts should include instructions about current IPC recommendations. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. The Facility's Infection Prevention and Control Program, dated 2019, documents the intent of this regulation is to ensure that the facility: * Develops and implements an ongoing infection prevention and control program (IPCP) to prevent, recognize, and control the onset and spread of infection to the extent possible and reviews and updates the IPCP annually, based upon the facility assessment and as necessary. This would include revision of the IPCP as national standards change. *Establish facility-wide systems for prevention, identification, investigation and control of infections of residents, staff, and visitors. It must include an ongoing system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility and procedures for reporting possible incidents of communicable disease or infections. Elements of the program include: * Program oversight including planning, organizing, implementing, operating, monitoring, and maintaining all of the elements of the program and ensuring that the facility's interdisciplinary team is involved in infection prevention and control. * The facility will designate one or more individuals as the infection preventionist(s) who is responsible for the facility's infection prevention and control program. * Surveillance, including process and outcome surveillance, will include monitoring, data analysis, documentation and communicable diseases reporting (as required by State and Federal law and regulation). Surveillance activities will be conducted to identify practice, infection trends and early identification of new infections and potential outbreak situations. *Antibiotic Stewardship and review including reviewing date to monitor the appropriate use of antibiotics in the resident population. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 - Many	The Facility's SARS-CoV-2 Infection Policy, dated [DATE], documents: Policy Statement: AS of today, the following COVID policy captures the most up to date information enabling us to be proactive in adopting practices to keep our residents, staff and visitors safe. The community/facility should follow county, state and federal recommendations applicable for SARS-CoV-2 Infection prevention and treatment. Sars-CoV-2 Infection Prevention: COVID-19 Vaccines: HCP (healthcare providers), residents, and visitors should be offered resources and counseled about the importance of receiving the COVID-19 vaccine. Additionally encourage everyone to remain up to date with all recommended COVID-19 vaccine doses. Ensure everyone is aware of recommended IPC (Infection Control Practices) in the facility. Post visual alerts (eg signs, posters) at the entrance and in strategic places. When to Implement Source Control Measures for Prevention: People particularly those at high risk for severe illness, should wear the most protective mask or respirator they can that fits well and that they will wear consistently. Source control is recommended for individuals in healthcare setting who: have suspected of confirmed SARS-CoV-2 infection or other respiratory infection, had close contact (residents and visitors) or higher risk exposure (HCP) with someone with SARS-CoV-2 infection for 10 days after exposure for skilled nursing facility residents. As SARS-CoV-2 transmission in the community (facility) increases, the potential for encountering asymptomatic or pre-symptomatic residents with SARS-CoV-2 infection also likely increases. In these circumstances healthcare facilities should consider implementing broader use of respirators and eye protection by HCP during resident care encounters as described below: NIOSH approved particulate respirators with N95 filters eye protection (ie goggles or face shield that covers the front and sides of the face) work during all resident care encounters. Optimizing the use of Engineering Controls and Indoor Air Quality: optimize the use of engineering controls to reduce or eliminate exposures by shielding HCP and other residents from infected individuals (eg physical barriers at reception/triage locations and dedicated pathways to guide symptomatic residents through waiting rooms and triage areas). Take measures to limit crowding in communal spaces explore options in consultation with facility engineers, to improve ventilation delivery and indoor air quality in resident rooms and all share spaces. Recommended infection prevention and control practices when caring for a resident with suspected or confirmed SARS-CoV-2 infection. The IPC recommendations described below (eg resident placement, recommended PPE) and also apply to resident with symptoms of COVID and asymptomatic residents who have met the criteria for empiric Transmission based precautions based on close contact with someone with SARS-CoV-2. However, these residents should NOT be cohorted with residents with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing. The empiric Transmission Based Precautions used for SARS CoV 2 if it suspected or confirmed is enhance droplet/contact/eye protection. Asymptomatic residents regardless of vaccination status with close contact with someone with SARS CoV2 infection should have a series of three viral tests for SARS CoV2 infection. Testing is recommended immediately (but not earlier than 24 hours after exposure) and, if negative, again 48 hours after the first negative test and if, negative again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is 0), day 3, and day 5. Examples of when empiric Transmission Based Precautions following close contact may be considered include: a skilled nursing facility resident is unable to be tested or wear source control as recommended for the 10 days following their exposure, resident is moderately to severely immunocompromised, resident is residing on a unit with others who are moderately to severely immunocompromised, resident is residing on unit experiencing ongoing SARS- CoV2 infection that is not control with initial interventions. Resident Placement with suspected or confirmed SARS-CoV2 infection: Place a resident with suspected or confirmed SARS-CoV2 infection in a single person room and placed in enhanced droplet/contact/eye protection. The door should be kept closed (if safe to do so). Ideally the resident should have a dedicated bathroom. If cohorting, only residents with the same respiratory pathogen should be housed in the same room. Facilities could consider designating entire units within the facility, with dedicated HCP, to care for residents with SARS-COV2 infection. Personal Protective Equipment: HCP who enter the room of a resident with suspected or confirmed SARS CoV 2 infection should adhere to enhanced droplet/contact/eye protection and use a NIOSH approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (ie goggles or a face shield that covers the front and sides of face).Resident with cognitive defect and or those resident in memory care: It may be difficult to maintain infection control practices including resident isolation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 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** 44967 Based on interview and record review, the facility failed to monitor, track, and properly document microbiology organisms on infection control log, and failed to monitor and follow up for proper antibiotic use for 2 of 6 residents (R10, R61) reviewed for Antibiotic Stewardship in the sample of 57. The Findings Include: 1. R10's Admission Record, undated, documents R10 was admitted to the facility on [DATE], with diagnoses of Alzheimer's disease, Dementia, Falls, and COVID-19. R10's Care Plan, dated 7/12/24, documents R10 is incontinent of bowel and bladder. Interventions: : Check frequently for incontinence, wash, rinse and dry perineum, change clothing PRN (as needed) after incontinence episodes, monitor/document/report to MD (Medical Doctor) PRN possible medical causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects, uses briefs. It continues R10 a has an Activities of Daily Living (ADL) Self Care Performance Deficit due to Alzheimer's Disease, weakness, muscle wasting and atrophy. Interventions: R10 is able to use the restroom independent, supervision required at times due to dementia. R10's Minimum Data Set (MDS), dated [DATE], documents R10 has a severe cognitive impairment and requires partial/moderate assistance from staff for toileting and bathing and is always incontinent of urine and frequently incontinent of bowel. R10's Urinalysis, dated 8/11/24, documents a Urine Culture will be done. R10's Nursing Note, dated 8/11/24 at 3:36 PM, documents, Resident returned to facility via wheelchair with ER (emergency room) nurse at 15:37. ER DX (diagnosis) - UTI (Urinary Tract Infection), given 16 MG (milligram) Rocephin IV (intravenous) and fluids in ER. New orders received for Cipro 250 MG BID (twice a day) for 7 days starting 8/12/24. Check on urine culture in 48 hours. MD notified. R10's Physician Order, dated 8/11/24, documents, Cipro Oral Tablet 250 MG, Give 250 MG by mouth two times a day for UTI until 8/19/2024 23:59. R10's Nursing Note, dated 8/13/24 at 7:57 PM, documents, Remains on ABT (antibiotic) for UTI, no adverse reaction noted. Fluids encouraged. Voiding qs (unknown) incontinent. No acute distress noted. R10's Nursing Note, dated 8/20/24 at 9:58 AM, documents, Resident completed antibiotic today. The Facility's Infection Surveillance Log, dated August 2024, documents R10 had a UTI, dated 8/11/24 with Urine Culture done on 8/11/24. There was no Urine Culture seen in R10's Medical Record, with no follow up in 48 hours as documented in the Nursing Note on 8/11/24 at 3:36 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R61's Admission Record, undated, documents R61 was originally admitted to the facility on [DATE], with diagnoses of Dementia, Sepsis, Cellulitis, Emphysema, Dysphagia, Psychotic disorder, Chronic Kidney Disease, and COVID-19. R61's Care Plan, dated 7/18/24, documents R61 is incontinent of bowel and bladder. Interventions: Check R61 for incontinence, wash, rinse and dry perineum, change clothing PRN after incontinence episodes, monitor/document for s/sx (signs/symptoms) UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. It continues R61 has C. Difficile (C-Diff). Interventions: Contact Isolation: Wear gowns and masks when changing contaminated linens, educate resident/family/staff regarding preventive measures to contain the infection. R61 requires isolation - Contact related to C-Diff. Interventions: Isolation per facility protocol. It continues R61 has ADL Self Care Performance Deficit related to weakness and impaired cognition. Intervention: The resident requires one staff participation to use toilet. R61's MDS, dated [DATE], documents R61 has a severe cognitive impairment and is dependent on staff for toileting and bathing. R61 is always incontinent of both bowel and bladder. R61's Stool Culture, dated 8/2/24, documents R61 was positive for Clostridium Difficile (C-Diff). R61's Nursing Note, dated 8/2/24 at 8:24 PM, documents, Received N.O. (New Order) obtain stool specimen for C-Diff toxin. R61's Nursing Note, dated 8/2/24 at 9:10 PM, documents, Stool specimen obtained as ordered for C-Diff, Specimen labeled and taken to lab. R61's Nursing Note, dated 8/3/24 at 9:32 AM, documents R61's stool sample came back positive for C-Diff. Writer called R61's provider and left message to have him contact our facility regarding result of C-diff. R61's Nursing Note, dated 8/3/24 at 9:43 AM, documents, Per (Provider) N.O. for Flagyl 500 MG TID (three times a day) x 10 days. POA (Power of Attorney) aware, order placed in chart. R61's Nursing Note, dated 8/14/24 at 12:49 PM, documents, Resident completed ABT (antibiotic) Flagyl early this AM. No adverse effects noted or observed. Will continue to monitor. Resident currently sitting up in dining room eating lunch. R61's Physician Order, dated 8/3/24, documents, Metronidazole 500 MG Tablet, Give 1 tablet by mouth 3 times a day for C-Diff X 10 Days. The Facility's Infection Surveillance Log, dated August 2024, does not include R61 on this log. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 10:30 AM, when asked how she becomes aware of a resident with a new infection, V2, Director of Nursing (DON)/Infection Preventionist (IP), stated, The Nurses will tell us that a resident has an infection, and we will make sure they are on the correct precautions. When asked how they know the resident is on the correct antibiotic, V2 stated, We are supposed to be checking the C&S (Culture and Sensitivity) and see if they are on the correct antibiotic, and if not, call the physician to have the order changed. When asked if this is happening, V2 stated, I'm not going to lie, I don't believe that is getting done. On 9/18/24 at 1:20 PM, V2, DON, and V8, Assistant Director of Nursing (ADON), was interviewed about Infection Control with a Review of the Infection Control book. V2 stated, I print out the numbers off the corporate website that shows the infections in this facility. I will look at the McGeer's criteria and if the infection does not meet those criteria, I put a No in the Treatment Appropriate column of the spreadsheet. When asked what she does with this information after determining the treatment was not appropriate, V2 stated, I guess we don't do anything. Sometimes the antibiotics are already completed by the time I get the information, so it is too late. When asked what the plans or next steps are to correct this, V2 stated, The plan is to retrain the nurses to Stop and Watch, meaning if a resident has signs/symptoms of a UTI (Urinary Tract Infection), for example, they should make sure that resident is hydrated and watch for further symptoms. Sometimes the ball gets dropped and nothing gets done. Upon review of the Infection Control Log, there is nothing documented since the end of August (31st) 2024. V2 stated, With all the DON duties and trying to train (V8) to do Infection Control, I have not had time to do anything with it. On 9/19/24 at 8:30 AM, V2 stated, Just to let you know, I am already working on the POC (Plan of Correction) and working on getting everything updated for September. On 9/25/24 at 8:40 AM, V1, Administrator, stated, I would expect the Infection Preventionist to keep up with the infection surveillance and the antibiotic stewardship daily, weekly, and monthly to make sure residents are on the correct antibiotic and treatments. The Facility's Infection Prevention and Control Policy, dated 2019, documents, It is the policy that this facility's Infection Prevention and Control Program (IPCP), is based upon information from the Facility Assessment and follows national standards and guidelines to prevent, recognize and control the onset and spread of infection whenever possible. The Infection Prevention and Control Program includes: 1. A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to regulatory requirements and following accepted national standards. 3. An Antibiotic Stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Infection Prevention and Control Manual Antibiotic Stewardship & MDROs Policy, dated 2019, documents, Antibiotic Stewardship refers to systematic efforts to optimize the use of antibiotics - not just reduce the total volume used - to maximize their benefits to patients, while minimizing both the rise and antibiotic resistance as well as adverse effects to patients from unnecessary antibiotic therapy. Stewardship involves identifying the microbe responsible for disease, utilizing evidence based definitions when indicated; selecting the appropriate antibiotic along with documentation indicating the rationale for use, appropriate dosing, route, and duration of antibiotic therapy; and to ensure discontinuation of antibiotics when they are no longer needed. The organization will identify positions that will have the authority to hold others accountable for compliance with the facility Antibiotic Stewardship program. Infection Preventionist (IP): The IP will be responsible for surveillance, infection definition based on standards of practice, education, tracking, data management, analysis of data, communication with the DON, Medical and Consultant Pharmacist and ongoing system review. Tracking and Reporting of antibiotic use and outcomes will be completed in the facility to identify adherence to facility policy and procedures, use and outcomes. Tracking will allow the facility to identify patterns, prevalence of antibiotic use as well as specific ordering data. Outcomes (i.e. adverse drug events, antibiotic resistant organisms, C. difficile infections, etc.) will be tracked by the infection preventionist and discussed with the Quality Assurance Committed for action planning. The Facility's Infection Prevention and Control Program, dated 2019, documents the intent of this regulation is to ensure that the facility: *Develops and implements an ongoing infection prevention and control program (IPCP) to prevent, recognize, and control the onset and spread of infection to the extent possible and reviews and updates the IPCP annually, based upon the facility assessment and as necessary. This would include revision of the IPCP as national standards change. *Establish facility-wide systems for prevention, identification, investigation and control of infections of residents, staff, and visitors. It must include an ongoing system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility and procedures for reporting possible incidents of communicable disease or infections. Elements of the program include: *Program oversight including planning, organizing, implementing, operating, monitoring, and maintaining all of the elements of the program and ensuring that the facility's interdisciplinary team is involved in infection prevention and control. *The facility will designate one or more individuals as the infection preventionist(s) who is responsible for the facility's infection prevention and control program. *Surveillance, including process and outcome surveillance, will include monitoring, data analysis, documentation, and communicable diseases reporting (as required by State and Federal law and regulation). Surveillance activities will be conducted to identify practice, infection trends and early identification of new infections and potential outbreak situations. *Antibiotic Stewardship and review including reviewing date to monitor the appropriate use of antibiotics in the resident population.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on record review and interview, the facility failed to provide education, obtain consents, and administer influenza vaccine to 4 of 8 residents (R61, R77, R82, R23) reviewed for immunizations in the sample of 57. The Findings Include: 1. R61's Admission Record, undated, documents R61 was originally admitted to the facility on [DATE], with diagnoses of Dementia, Sepsis, Cellulitis, Emphysema, Dysphagia, Psychotic disorder, Chronic Kidney Disease, and COVID-19. R61's Care Plan, dated 7/18/24, documents R61 is incontinent of bowel and bladder. Interventions: Check R61 for incontinence, wash, rinse and dry perineum, change clothing PRN after incontinence episodes, monitor/document for s/sx (signs/symptoms) UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. It continues R61 has C. Difficile (C-Diff). Interventions: Contact Isolation: Wear gowns and masks when changing contaminated linens, educate resident/family/staff regarding preventive measures to contain the infection. R61 requires isolation - Contact related to C-Diff. Interventions: Isolation per facility protocol. It continues R61 has ADL Self Care Performance Deficit related to weakness and impaired cognition. Intervention: The resident requires one staff participation to use toilet. R61's Minimum Data Set (MDS), dated [DATE], documents R61 has a severe cognitive impairment and is dependent on staff for toileting and bathing. R61 is always incontinent of both bowel and bladder. R61's Electronic Medical Record, under Immunizations, documents R61 was last given the Influenza vaccination on 10/29/21. There is no further documentation of R61 being offered or given the Influenza vaccination. 2. R77's Admission Record, undated, documents R77 was admitted to the facility on [DATE], with diagnoses of Dementia, Osteoarthritis, Osteoporosis, Falls, and Atrial Fibrillation. R77's Care Plan, dated 9/4/24, documents R77 requires droplet isolation related to COVID 19 positive. It continues R77 has an ADL Self Care Performance Deficit Dementia. R77's MDS, dated [DATE], documents R77 has a severe cognitive impairment and requires moderate to substantial assistance from staff for ADLs. R77's Electronic Medical Record, under Immunizations, documents R77 has not received or was offered the Influenza vaccination. There were no consents or refusals documented. 3. R82's Admission Record, undated, documents R82 was admitted to the facility on [DATE], with diagnoses of Alzheimer's disease, Dementia, Major Depressive disorder, Anxiety disorder, and COVID-19. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R82's Care Plan, dated 9/4/24, documents R82 will remain in the facility long term. It continues R82 has an ADL Self Care Performance Deficit. R82's MDS, dated [DATE], documents R82 has a severe cognitive impairment and requires partial to substantial assistance from staff for ADLs. R82's Electronic Medical Record, under Immunizations, documents R82 has not received or was offered the Influenza vaccination. There were no consents or refusals documented. 4. R23's Admission Record, undated, documents R23 was admitted to the facility on [DATE], with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Morbid Obesity, Anxiety disorder, Depression, Asthma, Idiopathic Peripheral Neuropathy, and Congestive Heart Failure (CHF). R23's Care Plan, dated 7/30/24, documents R23 has an ADL Self Care Performance Deficit. It continues R23 resident has Asthma. R23's MDS, dated [DATE], documents R23 is cognitively intact and is dependent on staff for ADLs. R23's Electronic Medical Record, under Immunizations, documents R23 has not received or was offered the Influenza vaccination. There were no consents or refusals documented. On 9/18/24 at 1:30 PM, when asked for a list of residents who have refused, consented, or received any vaccinations, V2, DON, stated, I don't have a list. It should be scanned into the resident's medical record if they have one. The CDC (Center for Disease Control) has a large and complicated algorithm to follow for the Pneumococcal and other vaccinations. On 9/19/24 at 8:30 AM, V2 stated Just to let you know, I am already working on the POC (Plan of Correction) and working on getting everything updated for September. On 9/25/24 at 8:40 AM, V1, Administrator, stated, I would expect the Infection Preventionist to keep up with the residents immunizations, including influenza and Pneumococcal when needed. The Facility's Infection Prevention and Control Resident Immunizations and Vaccinations Policy, dated 2019, documents, It is the policy of this facility that residents will be offered immunization against pneumococcal and influenza diseases. Purpose: to reduce the incidence of pneumococcal and influenza diseases and the morbidity and mortality attributed to these infections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility's Infection Prevention and Control Program, dated 2019, documents the intent of this regulation is to ensure that the facility: *Develops and implements an ongoing infection prevention and control program (IPCP) to prevent, recognize, and control the onset and spread of infection to the extent possible and reviews and updates the IPCP annually, based upon the facility assessment and as necessary. This would include revision of the IPCP as national standards change. *Establish facility-wide systems for prevention, identification, investigation, and control of infections of residents, staff, and visitors. It must include an ongoing system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility and procedures for reporting possible incidents of communicable disease or infections. Elements of the program include: *Program oversight including planning, organizing, implementing, operating, monitoring, and maintaining all the elements of the program and ensuring that the facility's interdisciplinary team is involved in infection prevention and control. *The facility will designate one or more individuals as the infection preventionist(s) who is responsible for the facility's infection prevention and control program. *Surveillance, including process and outcome surveillance, will include monitoring, data analysis, documentation, and communicable diseases reporting (as required by State and Federal law and regulation). Surveillance activities will be conducted to identify practice, infection trends and early identification of new infections and potential outbreak situations. *Antibiotic Stewardship and review including reviewing date to monitor the appropriate use of antibiotics in the resident population.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 44967 Based on interview and record review, the facility failed to offer, provide, and track COVID vaccines, boosters, and immunizations. This failure has the potential to affect all 93 residents residing in the building. The Findings Include: V2, Director of Nursing (DON), is the facility's Infection Preventionist (IP), with a Certification on file dated 4/3/22. V8, Assistant Director of Nursing (ADON), is also the facility's IP with a Certification on file, dated 6/27/24. On 9/18/24 at 10:25 AM, V2 stated, Both me and (V8) are certified Infection Preventionist for this facility, but (V8) does most of the work with it. On 9/18/24 at 1:25 PM, when asked about resident Influenza and other resident vaccinations, V8 stated, We just received the Influenza vaccination this past Thursday (9/12/24). (V2) started asking residents last week and we have been asking this week as well if they want the vaccination. I will be going through each resident's medical record and checking their immunizations. If needed, I will follow up to make sure they get them. On 9/18/24 at 1:30 PM, when asked for a list of residents who have refused, consented, or received any vaccinations, V2, DON, stated, I don't have a list. It should be scanned into the resident's medical record if they have had one. The CDC has a large and complicated algorithm to follow for the Pneumococcal and other vaccinations. On 9/18/24 at 2:00 PM, when asked how many residents are positive with COVID-19, V2 stated, I really don't know. There may have been some come off already. When asked who and when they are testing for COVID-19, V33, Regional Director, stated, Per our policy, we test after our first positive and after day five and day seven and once we have another positive, we start over again until we are negative. We will put a list of residents who are positive with COVID and who have been tested . On 9/19/24 at 2:04 PM, when asked what his expectations are of the facility vaccinating the residents, V40, Medical Director, stated, All residents in the facility should definitely be vaccinated against COVID and the Influenza. This should have already been started in September. I feel that any resident who gets COVID has the potential for serious harm and/or death. The vaccination, if administered, would improve, or at least diminish, the harm and severity of the disease. I would expect the facility to keep up with the vaccinations, especially COVID and Influenza, and I will be working with them to get this done. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/18/24 at 2:15 PM, after being asked for a list of residents and staff who are positive for COVID-19, V1, Administrator, and V33, Regional Director, provided a LTC (Long Term Care) Respiratory Surveillance Line List, handwritten, and dated 8/16/24. This list documents R78 was the only resident, along with two staff members, who were COVID Positive. R78 tested positive on 8/10/24, V6, LPN, tested positive on 8/8/24, and V42, Housekeeper, tested positive on 8/10/24. On 9/23/24 at 8:33 AM, V6 stated at the end of July, he felt kind of sick over a weekend that was his regularly scheduled weekend off. V6 stated he had a little bit of sinus problems, but felt fine by Monday. V6 stated he did not test for COVID when he came back to work, and was never confirmed positive. V6 stated if he thought he had COVID, he would have tested before returning to work. V6 stated he mentioned to coworkers after they had an employee test positive, that maybe he did have COVID at the end of July, however, now he thinks he didn't have COVID. V6 stated he did get boosters from the health department because no one at the facility has offered him a booster. V6 stated he doesn't work the 100-Unit. V6 stated he heard V13, Dietary Aide, was positive last month. On 9/23/24 at 8:48 AM, V23, Registered Nurse (RN), stated she was COVID positive on 8/18/24. V23 stated she worked the 100-Unit on 8/14/24, and was supposed to work on 8/18/24, but she was not feeling well, so tested for COVID, and noted to be positive. V23 stated she was offered the COVID vaccination in 2021 and 2022, but declined and has not been offered since. V23 stated she thought they handed out some COVID education papers at one time. V23 stated she usually works on the 100-Unit, unless she is extra or the community nurse, then helps everywhere. V23 stated everyone is supposed to wear N-95 mask upon walking through the 100-unit doors and full PPE, gown, gloves, face shield, mask upon walking into a resident room. V23 stated she sees visitors coming and going in and out of the 100-hall doors without anything on, no mask or anything. V23 stated she tries to educate them but is usually told, I don't care. On 9/23/24 8:51 AM, V27, Certified Nursing Assistant (CNA), stated she just started at the facility on 9/3/24 after just getting over COVID 2 weeks prior from a different facility. V27 stated she is aware of some staff getting COVID, but is unsure of names. V27 stated she has never been offered the COVID vaccination at this facility, and has not had any kind of COVID education offered. V27 stated she mostly works the 200-hall, but has worked the 100-hall before. V27 stated all she was told she had to wear in the 100-Unit was the N-95 mask and she has never been told she had to wear gown, gloves, or face shield, and she was unaware that she was supposed to. On 9/23/24 at 9:03 AM, V44, Dietary Aide, stated he was tested two days ago and he tested himself due to the high risk in the facility. V44 stated he is aware of one person in Laundry that was COVID positive a month or so ago, and that V13 was also positive. V44 stated he was vaccinated in 2021 and 2022 with boosters, and he went to the local health clinic to get them. V44 believes he did receive COVID information from the facility. V44 stated he only works in the kitchen. V44 stated he uses a mask, gloves, and washes his hands, but does not wear gown or eye protection. On 9/23/24 at 9:06 AM, V11, Dietary Manager, stated she was tested about one and half weeks ago, and she tested negative. V11 stated she had two employees, V48, Dietary Aide, and V13, Dietary Aide. V11 stated she has not been offered the COVID vaccination or COVID education from the facility. V11 stated they don't have to wear PPE in the kitchen, but if staff are going into the 100-unit, they should be wearing gown, gloves, face shield, and mask. V11 stated her staff go into the unit two to three times a day to deliver meals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/23/24 at 9:12 AM, V45, LPN, stated she tested last week on Monday and Thursday and was negative. V45 stated she knows (V49, CNA), tested positive last week, and is now off work. V45 stated she was vaccinated, but it was at other places and not at this facility, has not been offered vaccination or education at facility. V45 stated she works each floor because she is the Restorative Nurse. V45 stated if any staff is going into the 100-Unit, they are supposed to wear a N-95, a gown, gloves, and a face shield, because those residents are walking around everywhere. On 9/23/24 at 10:35 AM, V48, Cook/Maintenance, stated he was PT (part time) Maintenance and PT [NAME] at the facility. V48 stated on either 9/6/24 or 9/13/24, he came into work and wasn't feeling well, and told him mother (V1), and she advised him to test for COVID, and he tested positive. V48 stated V13, DA Dietary Aide, also tested positive. V48 stated he was not offered the COVID vaccination, and his mom (V1) told him there is a COVID packet of information he can have if he wanted it, and he declined. V48 stated he is a [NAME] and cooks the food for all residents. V48 stated the Dietary Aide typically takes the food to the halls, and he will only do it if someone requests a special tray that he will make up and deliver to that resident. On 9/23/24 at 3:00 PM, V47, Housekeeper, was seen coming out of the 100-hall pushing her housekeeper cart. When asked about the cart, V47 stated she uses the same cart throughout the facility. When asked about her process for coming out of the COVID hall (100-hall), V47 stated she takes her cart and cleans everywhere that needs to be cleaned, halls, resident rooms, restrooms, ect., and when she gets done with the 100-hall, she will take the cart to the housekeeping closet, on the 400-hall, and will put her soiled mop head and rags in a barrel and then dump the mop water and trash. V47 stated the Laundry Department will pick up the soiled mop heads and wash them. V47's Housekeeping cart had a large trash container on side of cart that appeared full of trash and not covered. When asked, V47 stated that was from the 100-hall. V47 stated they do have other housekeeping carts in the facility, but was never aware to use one specific cart for the COVID Unit/Isolation rooms. R47 was seen dumping the contaminated mop water from the 100-hall into a large sink in the closet with no gloves or other PPE on. On 9/18/24 at 2:15 PM, V1 and V33 provided a LTC (Long Term Care) Respiratory Surveillance Line List, dated 9/18/24. This list has seven residents listed who have tested positive with COVID-19, ranging in dates from 9/4/24 to 9/12/24. On 9/19/24 at 9:00 AM, V1 and V33 also provided a LTC (Long Term Care) Respiratory Surveillance Line List, dated 9/19/24. This list has one staff member and one resident who tested positive for COVID. On 9/19/24 at 9:05 AM, V33 also provided a handwritten list of residents who were tested , including the dates tested . This list documents the first positive COVID was on 8/31/24 was R82, which is different than previous list given. On 9/24/24 at 3:00 PM, when asked about offering the residents and staff the COVID vaccination and/or booster, V2, DON, stated, After it was mandated in 2022, I don't recall doing anything after that, but I also was not here in 2022. On 9/25/24 at 8:40 AM, V1, Administrator, stated, I would expect all staff to maintain all COVID precautions, including tracking, testing, and offering education and vaccinations as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	There is nothing documented in the Infection Surveillance log since the end of August (31st), including all residents who currently are COVID-19 Positive. V2 stated, With all the DON duties and trying to train (V8) to do Infection Control, I have not had time to do anything with it. The Facility's SARS-CoV-2 Infection Policy, dated 8/22/24, documents, HCP (Health Care Providers), Residents, and Visitors should be offered resources and counseled about the importance of receiving the COVID-19 vaccine. Additionally encourage everyone to remain up to date with all recommended COVID-19 vaccine doses. Ensure everyone is aware of recommended IPC (Infection Prevention Control) practices in the facility. Post visual alerts at the entrance and in strategic places. These alerts should include instructions about current IPC recommendations. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Rehab & Hcc	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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 33205 Based on interview and record review, the facility failed to ensure Nurse Aides completed the required 12 hours of education per year. This has the potential to affect all 93 residents residing in the facility. Findings include: 1. The facility's employee files documented the following: V73, Certified Nurse Assistant, (CNA) hire date of 10/20/21. V74, CNA hire date of 8/2/2023 V75, CNA hire date of 9/1/2020 V76, CNA hire date of 1/17/2022 V73's computer education report, dated 9/1/23-9/25/23, documents V73 had 1.75 hours of education for the past year. V74's computer eduction report, dated 9/1/23-9/25/23, documents V74 had 0.5 hours of eduction for the past year. V75's computer education report, dated 9/1/23-9/25/23, documents V75 had no education hours documented for the past year. V76's computer eduction report, dated 9/1/23-9/25/23, documents V76 had 2 hours of eduction for the past year. On 9/24/24 at 3:15PM, V2, Director of Nursing, stated she is not sure how many education hours CNA's are required to complete annually. On 9/25/24 at 1:00PM, V33, Regional Director, stated she is unsure how mnay hours CNAs are required to complete annually, but would check. V33 stated the facility's computerized education system does not always give hours for each course, and inservice logs do not say how long trainings are, so she has no way of knowing how many hours CNAs have. On 9/25/24 at 2:09 PM, V33 stated they do not have a policy for CNA education. The Facility's Medicare and Medicaid Application, dated 9/16/24, documents there are 93 residents residing in the facilty.