STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145704	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apostolic Christian Home	1102 West Randolph Roanoke, IL 61561

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33975 Based on observation, interview and record review the Facility failed to follow the policy for documenting and monitoring a skin issue for one of 14 Residents (R7) reviewed for skin issues in a sample of 14. Findings include: The Facility Policy and Procedure for Assessment and Treatment of Skin Wounds, reviewed 2/1/24, documents: skin assessments will be done on admission, weekly by tub room and Certified Nursing Assistant (CNA) will call in the Director of Nursing (DON) or nurse on duty if changes and daily by CNA's providing care; all treatments will be monitored daily by the charge nurse and/or skin nurse and documented in the Electronic Treatment Record (ETAR); if a new skin breakdown is first noticed by the CNA, they will obtain a Skin Incident Report sheet found at the nurse's stations; they will fill out the appropriate portion of the form with the Resident name, description of skin issue, signature, date and shift, this form is then given to their nurse or directly reported to the nurse on duty; obtain a baseline measurement and assess the area then complete the remaining questions and initiate wound care; place the completed form in the DON/Skin Nurse folder; also notify the Physician and Resident's family; chart in Progress Notes (new skin observed, overall appearance of the wound, interventions taken and that the Family, Physician and Skin Nurse have been notified; a wound management will be initiated to track and provide weekly documentation; this documents ongoing assessments during healing until the wound or skin issues is healed or resolves; a photo of the wound will be taken at the discretion of the Charge Nurse/Skin Nurse; document overall condition of wound surrounding skin, warmth, edema, pain, drainage amount, color and any odor in the progress notes; and the Skin Treatment Nurse will measure and document on all skin wounds weekly in the Wound Management tab of the electronic medical record. The Facility Wound Summary Report, dated 1/21/25, does not document R7's Right Foot measurements or wound description. R7's Progress Notes, dated 12/10/24 through 1/21/25, does not document R7's Right Foot measurements or wound description. R7's Treatment Record, dated 12/10/24 through 1/21/25, does not document R7's Right Foot measurements or wound description. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's Skin Incident Report, dated 12/22/24, documents a Right Heel skin incident that measures 3.0 centimeters/cm by 4.0 cm. The Skin Incident Report does not document that R7's Physician or Family were notified of the skin issue or care plan interventions. On 1/23/25 at 11:22 am, V15 (Licensed Practical Nurse/LPN) stated, I am a night shift nurse, and on the night of 12/22/24, we discovered a quarter size, dark brown with hard center area on (R7's) Right Heel/Calcaneous Heel Bone), I was not sure if it was a pressure ulcer or callous. I wanted to get a treatment on it, so I put some barrier ointment (Skin Prep) and gave (R7) some pressure ulcer boots to wear while in bed, to prevent any further skin breakdown. V15 confirmed that no documentation was entered in to R7's medical record at that time. I was the only nurse working and I got so busy, that I never went back and measured or documented the area on (R7's) Right Heel. We are supposed to fill out a Skin Incident Report, I put (R7's) name at the top of one and never went back and filled it out. I am so sorry, I know that I should have measured it and documented the skin area in the R7's chart, but I forgot. I cannot even remember how big it was or anything anymore. I did not notify (R7's) Responsible Party of the new area found. On 1/22/25 at 11:25 am, V8 (License Practical Nurse/LPN/Wound Nurse) performed wound care (skin barrier) to R7's Right Foot (Calcaneous Heel Bone). R7's Calcaneous Heel Bone had an approximate quarter size, intact black scabbed area, with no drainage. V8 stated, There is no Right Heel skin documentation in (R7's) progress notes. We classified this as a callous, and I do not do weekly skin measurements on any skin issue unless it is a pressure ulcer. On 1/23/25 at 11:35 am, V2 (Director of Nursing/DON) stated, We do not have any documentation in the Nursing Progress Notes on (R7's) Right Heel. Regardless that (R7) admitted on [DATE], to the Facility for a Right Hip fracture, required staff assistance for bed mobility and developed this skin breakdown on 12/22/24, I still classified this as a callous. We do not track measurements or wound description on any skin issues other than pressure ulcers, we can tell just by looking at it week to week, if it getting better or worse.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50962 Based on observation, interview, and record review, the facility failed to ensure hand sanitation after glove changes were completed during pressure ulcer dressing changes for one resident (R4) of three residents reviewed for pressure ulcers in a sample of 14. Findings include: The facility's policy titled Standard Precautions, revised 11/3/2025, documents, Purpose: Standard Precautions refer to the infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Standard precautions are based on the principle that all blood, body fluids, secretions, visible blood, non-intact skin, and mucous membranes may contain transmissible infectious agents. Furthermore, equipment or items in the resident's environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents. Standard precautions include hand hygiene, proper selection and use of personal protective equipment, safe injection practices, respiratory hygiene/cough etiquette, environmental cleaning and disinfection, and reprocessing of reusable resident medical equipment. 1. Wash your hands or use hand sanitizer each time you remove your gloves. R4's resident face sheet documents R4's date of admission to the facility was 8/7/23 and diagnosis on admission include: Metabolic Encephalopathy, non-pressure chronic ulcer of buttock limited to breakdown of skin-Moisture Associated Skin Damage (MASD inner gluteal clef, Type 2 Diabetes Mellitus with Foot Ulcer of Right Heel, Pressure Ulcer of Right Heel Stage Three-from Deep Tissue Injury (DTI)/Diabetic Ulcer, and Chronic Kidney Disease Stage Three B. R4's Minimum Data Set assessment (MDS), dated [DATE], documents R4 has one Stage Three Pressure Ulcer, Diabetic Foot Ulcer, and Moisture Associated Skin Damage (MASD). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25, at 10:15 am, R4 was lying in bed in a prone position. V8 (Wound Nurse/Licensed Practical Nurse) and V9 (Certified Nursing Assistant/CNA) entered room, performed hand hygiene and donned gown and gloves. V8 (Licensed Practical Nurse/LPN) cleaned the over the bed table and prepared treatment supplies to perform suprapubic catheter site care, wound care to bilateral Buttocks and Right Heel. V8 removed R4's suprapubic catheter dressing, scant amount of brownish drainage present on dressing and insertion site reddened and disposed of soiled dressing. V8 (LPN) removed soiled gloves and donned a new pair of gloves but did not perform hand hygiene in between glove change. V8 (LPN) cleansed suprapubic site, kept gloves on and placed a new dry dressing. V9 (CNA) positioned R4 onto R4's left side and V8 (LPN) then proceeded to remove soiled dressings to bilateral buttocks/gluteal folds with the same gloves V8 (LPN) wore prior, when cleansing and placing the suprapubic dressing. V8 disposed of the soiled dressings from buttocks, removed gloves, and donned a new pair without performing hand hygiene. V8 (LPN) proceeded to cleanse moisture associated skin damage (MASD) to bilateral buttocks, place sure prep around wounds, removed gloves, disposed of them and donned new gloves without performing hand hygiene. V8 (LPN) then measured wounds (left buttock measured 1.5 cm (centimeters) x 1.5 cm and right buttock measured 4.0 cm x 2.5 cm), placed collagen sheet to wound beds on bilateral buttocks and applied foam dressings. V8 (LPN) removed gloves, disposed of them and placed new gloves on without performing hand hygiene. V4 (CNA) removed R4's right sock and held right leg/foot while V8 (LPN) removed soiled dressing, small amount of yellowish drainage noted on dressing, then measured right heel wound (1.5 cm x 3.0 cm), applied skin prep to peri-wound, removed soiled gloves, and donned a new pair of gloves without performing hand hygiene. V8 (LPN) placed collagen sheet to wound bed, applied barrier cream to peri-wound and then dressing. V8 removed gloves, gown and proceeded to wash hands. On 1/22/25, at 10:40 am, V8 (LPN) stated that she gets confused about when hand hygiene should be performed but agreed that it probably should be done with every glove change. V8 (LPN) also stated that gloves should be changed between performing treatments to different body sites to prevent cross contamination. On 1/22/25, at 10:49 am, V2 (Director of Nursing/DON) stated, our wound care policy does not indicate the need to wash hands between glove changes, however I'm hanging myself here by giving you this (hands over Facility Standard Precautions Policy) because it does state this (V2/DON points to section in Standard Precautions Policy that documents, Wash hands or use hand sanitizer each time you remove your gloves.).

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 33970 Based on record review and interview the facility failed to utilize a set standard to determine infections. This failure has the potential to affect all 48 residents who currently reside in the facility. Findings Include: The Facility's Antibiotic Stewardship policy dated 1/3/25 documents Antibiotic stewardship refers to a set of commitments and activities designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The medical director, pharmacist and the DON (Director of Nursing_ will demonstrate support and commitment to safe and appropriate antibiotic use at the (facility)_ The physicians, nursing staff and pharmacy will be responsible for promoting and overseeing antibiotic stewardship activities at the (facility) . This process will be in place for a review of antibiotics by the IP (Infection Preventionist) on a weekly basis. Was an antibiotic event filled out by the nurse taking the MD (Doctor) order? If any of the below questions can't be answered the IP will contact the MD ordering the antibiotic in question. 1. Does the resident have a bacterial infection that will respond to antibiotics? 2. If so, is the resident on the most appropriate antibiotic, dose and route of administration? 3. Can the spectrum of the antibiotic be narrowed, or the duration of therapy shortened? 4. Would the resident benefit from the additional infectious disease antibiotic expertise to ensure optimal treatment of the suspected or confirmed infection? The facility's Infection Control monitoring logs for January 2024 through December 2024 do not include any documentation of use of McGeers Data for the determination of infections. On 01/22/25 at 10:00 AM V2 (Director of Nursing) stated that she reviews medications at the end of the month off of a pharmacy report and makes sure that there was documentation for the reasoning of the antibiotic. After V2 (DON) ensures that there is a diagnosis then V8 (Licensed Practical Nurse/Infection Preventionist) reviews the antibiotic orders to ensure that all antibiotics were warranted per McGeers Criteria. On 1/22/25 at 10:10 AM V8 (LPN/Infection Preventionist) stated the nurses are supposed to be using McGeers Criteria when communicating with the doctors about infections. V8 stated Some of our infections have not met the criteria to be considered infections. On 01/22/25 at 10:20 AM V2 (DON/Infection Preventionist) confirmed that she had been notified that some of the antibiotic medication orders were obtained for residents who did not meet the criteria for an infection. V2 confirmed that there was no documentation of any McGeers Criteria being followed for any of the facility's infections. I need to educate the floor nurses on the McGeers Criteria because by the time we (V2/DON and Infection Preventionist and V8 LPN and Infection Preventionist) review the antibiotics the residents have already been started on them. The facility's Application for Medicare and Medicaid dated 01/21/25 documents that 48 residents currently reside in the facility.