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	04/10/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation, interview, and record review, the facility failed to refer to residents who need assistance with feeding in a dignified manner during the lunch meal service. This has the potential to affect all 47 residents who reside in the facility.Findings include:Facility Resident Rights, reviewed 3/2011, documents You have the right to safety and good care. Your facility must provide services to keep your physical and mental health, and sense of satisfaction.Facility Your Rights and Protections as a Nursing Home Resident, undated, documents You have the right to be treated with dignity and respect.Facility Diets, provided by V4 Dietary Manager/DM on 4/7/26, documents there are two residents who get pureed diets, 10 residents get mechanical soft diets, and 35 residents get regular diets.On 4/8/26 at 12:13pm during the lunch time meal pass at the steam table in the kitchen which is located directly across from the serving window to the dining room, V4 Dietary Manager/DM told V8 [NAME] All the feeders are ready! in a loud voice facing the dining room residents when referring to the residents that needed assistance with their meals in the dining room. At that time, V8 verified V4 was referring to the residents who needed assistance with feeding which included two residents who are on pureed diets, and 10 residents who get mechanical soft diets. At the time V8 made the above statement the dining room was full of residents eating their lunch meal and within earshot of V4. On 4/8/26 at 12:20PM, V8 [NAME] verified five residents were getting room trays, one resident was out of the building for dialysis, and the rest of the residents (41) were in the dining room to eat.Facility Room Roster, dated 4/7/26, documents 47 residents reside in the facility.

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 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. Based on observation, interview, and record review, the facility failed to have an expiration or delivery date on bread and buns, failed to have current test strips to test the sanitation in the sanitizer container, failed to have test strips to test the temperature of the dishwasher, and failed to serve a lunch meal in a sanitary manner. This has the potential to affect all 47 residents who reside in the facility.Findings include: Facility Job Description for Dietary Cook, dated 12/11/18, documents The primary purpose of your job position is to prepare food in accordance with current applicable federal, state, and local standards, guidelines and regulations. To assure that quality food service is provided at all times. Food service personnel shall practice hygienic food handling techniques. Follow established Infection Control Policy.Facility Dietary- Receiving, Storage, and Issuing, dated January 2017, documents The Food Service Director is responsible for ordering, receiving, storing, and issuing all food items. In her absence, the Dietary Supervisor is responsible.Facility Infection Control, dated April 2026, documents The Dining Services Supervisor will supervise the cleaning and sanitizing of dishware and utensils, as well as the cleaning of the physical dining services department. The department will be maintained in a clean and sanitary manner to prevent foodborne illness. An approved dishwashing method and sanitizing agent/process will be used. Follow sanitizing agent manufacturer's instructions for use.Facility Steps to wash, rinse, and sanitize equipment and utensil, undated, documents for quaternary ammonium sanitizers, use according to directions with a minimum water temperature of 75 degrees. Sanitizer contact time is important.Facility Instructions to follow for cleaning and sanitizing the dining room tables using the Buckeye EC Sanitizer, undated, documents Get the clear, round, four-quart Cambro container, out of cabinet and fill with warm water and one pump of Pot N Pan detergent from the dispenser on the wall by the three-compartment sink.Facility Week at a Glance lunch meal on Wednesday 4/08/2026 at 12:00 PM was a fried chicken BLT/Bacon lettuce tomato sandwich, loaded tater tots, ranch dip, dill pickle spear, ice cream, fruit, salad, and milk.On 4/7/26 at 9:45AM, during the dietary tour with V4 Dietary Manager/DM, six packages of 12 count hamburger buns, and 16 loaves of white bread did not have an expiration or delivery date marked on them. At that time, V4 stated she did not know they did not have an expiration date marked on them and should have an expiration or delivery date on them. At that same time, the table sanitizer bucket was sitting on the three-compartment stainless steel sink in the kitchen, the dietary staff and V4 DM were unsure how to use the sanitizing strips, V4 DM tested the sanitizer bucket for sanitizer strength, and it did not meet the minimum for sanitizing strength. The dietary staff and V4 DM were unaware the sanitizing strips expired in June 2025. At that same time, the dietary staff and V4 DM were asked to check the dishwasher temperature by test strips to verify the dishwasher got up to temperature for sanitizing the dishes. The dietary staff and V4 DM were unsure where the dishwasher temperature test strips were, had never used the dishwasher temperature test strips before, and were unable to find any in the building. At that time, V4 DM stated she needed to order new sanitizer and dishwasher test strips.On 4/08/2026 from 12:00PM to 12:32 PM, kitchen staff were observed plating food during the lunch time meal. V8 [NAME] was observed multiple times touching her uniform with her gloves on to pull up her pants that were sliding down and did not perform hand hygiene or glove changes. At this same time, V8 was observed going to the warmer oven and opening the door on multiple occasions for pureed/soft foods or alternative meals residents ordered for lunch without changing her gloves or performing hand hygiene. The lunch meal was a fried chicken BLT/bacon lettuce tomato sandwich where V8 would use her gloved hand to pull out two pieces of bread from the bread bag, plate the resident's food, and then grab the chicken sandwich to cut into halves and put on resident's plates. At the same time, V4 Dietary Manager/DM was in the kitchen observing meal pass and reminded V8 not to touch her clothing and if she did, she needed to change her gloves and perform hand hygiene. Facility Room Roster, dated 4/7/26, documents 47 residents reside in the facility.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to document medication administration of controlled medications on the Controlled Drug Receipt/Record Disposition forms for five out of five residents (R4, R20, R23, R40, and R45) reviewed for controlled substance medication administration documentation in the total sample of 26.Findings include:The facility's policy titled, Controlled Substance-Administration, Count and Destruction, dated 8/5/25, documents when an individual controlled substance is given, the controlled substance must be counted before the medication is given and signed off in the EMAR (Electron Medication Administration Record). On 4/7/26 at 12:10 PM, V5/Licensed Practical Nurse (LPN) V5 pulled out R4's medication card of Lyrica (Schedule V Controlled Substance and Pain Medication) 25 mg (milligrams) from the locked narcotic drawer on the medication cart. V5 popped one capsule out of the medication card into a medication cup and administered the medication to R4 without signing out the medication on the Controlled Drug Receipt/Record Disposition Form. There were no controlled substance records on or in V5's medication cart. V5 confirmed R4's Lyrica is a controlled substance, and she did not update the narcotic count or sign out the medication on the Controlled Drug Receipt/Record Disposition Form when V5 administered the Lyrica to R4. V5 also confirmed there were no controlled substance records on the medication cart.On 4/7/26 at 12:25 PM, V5 provided the narcotic reconciliation book for V5's medication cart located in the medication storage room. R4's Controlled Drug Receipt/Record Disposition Form was reviewed with V5/LPN. V5 confirmed there was a discrepancy between the amount of Lyrica (Schedule V Controlled Substance and Pain Medication) capsules documented on the Controlled Drug Receipt/Record Disposition Form and the amount of Lyrica capsules in the medication card. The Controlled Drug Receipt/Record Disposition Form documented there were 21 capsules of Lyrica left. There were 19 capsules in R4's Lyrica medication card. V5 confirmed there were 19 capsules of Lyrica left in R4's Lyrica medication card. V5 stated R4 was given one capsule of Lyrica this morning and one capsule at noon, so the count is off by two capsules because the count on the Controlled Drug Receipt/Record Disposition Form was not updated since counting with the off-going nurse at the beginning of the shift that started at 6:00 AM. V5 stated V5 does not update the count for controlled medications and does not sign out controlled medications on the Controlled Drug Receipt/Record Disposition Form at the time they are administered during the shift. The binder with the Controlled Drug Receipt/Record Disposition Forms for each controlled medication is kept in the medication room while administering medications. The counts for each medication administered during the shift are updated and signed at the end of the shift before counting with the oncoming nurse. On 4/8/26 at 11:50 AM, a reconciliation of all controlled substances for [NAME] Hall was completed with V5/LPN, including controlled substances contained in the medication cart and refrigerator. Six discrepancies were identified for controlled substance medications during the reconciliation between the amounts documented on the Controlled Drug Receipt/Record Disposition Forms and the actual amount in the medication cards. R20's Controlled Drug Receipt/Record Disposition Form for Pregabalin (Schedule V Controlled Substance and Pain Medication) 25 mg capsule documented 28 capsules were left. R20's Pregabalin medication card had 27 capsules remaining; R23's Controlled Drug Receipt/Record Disposition Form for Pregabalin 75 mg capsule documented19 capsules were left. R23's Pregabalin medication card had 18 capsules remaining; R23's Controlled Drug Receipt/Record Disposition Form for Hydroco(done)-APAP (Acetaminophen) (Schedule II Controlled Substance and Pain Medication) 10-325 mg tablet documented 7 tablets were left. R23's Hydrocodone-Acetaminophen 10-325 mg medication card had 6 tablets remaining. R40's Controlled Drug Receipt/Record Disposition Form for Hydroco(done)-APAP (Acetaminophen) 5-325 mg tablets documented 25 tablets were left. R40's Hydrocodone-Acetaminophen 5-325 mg medication card had 24 tablets remaining. R45's Controlled Drug Receipt/Record Disposition Form for Lorazepam (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Schedule IV Controlled Substance and anti-anxiety medication) documented 52 tablets were left. R 45's Lorazepam card had 51 tablets remaining.On 4/8/26 at 11:56 AM, V5/LPN confirmed each of the discrepancies between the actual amount on hand and the amount documented on the Controlled Drug Receipt/Record Disposition Forms during the controlled substance reconciliation. V5 stated the controlled substance counts will be off until the end of V5's shift because the counts/records are not updated until the end of V5's shift before the controlled substances are reconciled with the oncoming nurse. V5 stated, I have always did it this way.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise a care plan to include the required information for a dialysis care plan and discontinue a diuretic off the care plan for one resident (R7) of 16 residents reviewed for care plan revision in a sample of 26.Findings include:On 4/07/2026 at 11:04 AM, R7 was alert and oriented, stated she gets dialysis three days a week on Monday, Wednesday, and Friday, and goes to East Peoria for hemodialysis. At that same time, R7 showed me her right upper arm fistula for dialysis.R7's Minimum Data Set/MDS, dated [DATE], documents R7 is cognitively intact, and dependent on renal dialysis.R7's Current Physician Orders, dated 3/9-4/9/26, documents Dialysis on Monday, Wednesday, and Friday. R7's current diagnoses include End Stage Renal Disease, and Dependence on Renal Dialysis dated 11/20/22. R7's current care plan has a problem start date of 12/31/21 Resident has a history of weight loss due to a daily diuretic.R7's dialysis care plan has no documentation of the following: Monitoring vital signs, weights, nutrition, and who to notify with concerns; Specific type and location of dialysis services, and the interventions and goals based upon the type of dialysis; If the resident receives Erythropoiesis-Stimulating Agent (ESA) therapy, what to monitor and when and to whom to report results; Which arm to use for blood pressure monitoring; Who to contact, such as the attending practitioner(s), nephrologist, and dialysis staff, for dialysis-related emergencies, concerns or complications; Monitoring for risk factors and managing complications such as hemorrhage, access site infection, hypotension, and to whom to report concerns; Assessment and care of the access site, including the use of PPE/Personal Protection Equipment as necessary, and other infection control measures; and the Approach to administering medications before, during, or after dialysis according to practitioner's orders.On 4/09/2026 at 2:33 PM, V16 CPC/care plan coordinator verified R7 was not on a diuretic (furosemide) anymore, needed taken off the care plan, and was discontinued 10/7/25. At that same time, R7 verified the dialysis care plan did not include what is required.

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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. Based on observation, interview, and record review the facility failed to perform hand hygiene with glove changes during urinary catheter care for one (R43) of two residents reviewed for catheter care in a sample of 26. Findings include: The facility's policy titled, Standard Precautions, review date 1/6/26, documents not in its entirety, Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes may contain hazardous drugs and/or transmissible infectious agents. Standard Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status. 1. You must wear gloves if you come into contact with blood, body fluids, or mucous membranes of any resident. Change gloves when they are torn. Change gloves after contact with each resident. There are glove holders in each room with a box of gloves for each resident. Wash your hands or use hand sanitizer each time you remove your gloves.R43's facility face sheet documents R43's date of admission to facility was 1/21/25 and R43's diagnoses include but not limited to Retention of urine, unspecified, Cutaneous-vesicostomy status Note: Suprapubic catheter 3/14/23, Personal history of Malignant Neoplasm of Prostate.Note:1995, Other Cerebral Infarction Note: Ischemic Stroke, Personal history of irradiation.R43's physician orders dated 3/1/26 documents R43 has an order for monthly suprapubic catheter change with an 18 French catheter and has orders to clean stoma daily with wound cleanser, apply collagen sheet cut to fit around stoma and cover with border dressing cut and taped T-pee style to stoma site.R43's current care plan documents R43 has a diagnosis of urinary retention and has a suprapubic catheter.On 4/08/2026 at 9:50 AM, V7 (Registered Nurse) observed doing suprapubic catheter care on R43. V7 performed hand hygiene, donned gown and gloves and laid out R43's treatment supplies on a clean surface. V7 used gloved hands to check R43's suprapubic site for old dressing but noted it was removed during shower. V7 removed her gloves and placed a new pair of gloves on without performing hand hygiene and then proceeded to cleanse around R43's suprapubic insertion site, then with a clean part of gauze, washed urinary catheter from insertion site and away from body. V7 removed gloves and placed new gloves on without performing hand hygiene and proceeded to place skin barrier and clean dressing. V7 then disposed of trash, gown, and gloves and performed hand hygiene.On 4/08/2026 at 10:05 AM, V7 (Registered Nurse) stated that she should have performed hand hygiene between glove changes.On 4/08/2026 at 10:15 AM, V2 (Director of Nursing) verified that hand hygiene should be performed between glove changes.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to implement interventions to prevent weight loss for one (R2) of two residents reviewed for weight loss in a sample of 26.Findings include: Facility Liberalized Diet policy, dated April 14, 2022, documents Advantages for the resident are as follows: Positive outcomes reported by similar programs include weight maintenance and/or gain. The following safety and diet concerns will be included: We will continue to use supplements that will be included in the medication passes, depending on the resident need. Resident weights will be obtained and reviewed in a consistent manner as to indicate weight gain or loss.Facility Weight Assessment and Intervention/Gain or Loss, revised 3/4/26, documents Weight Assessment. Negative trends will be evaluated by the dietary supervisor and dietitian to determine whether or not significant weight change has occurred. Dietary coordinator will report the significant changes to Registered dietitian and chart in the resident's progress notes the significant weight change. Dietary coordinator will monitor and record the resident's weight and intakes as recommended by the Dietician/Medical Doctor. Registered Dietician makes recommendations in the resident's chart and on the notification form to the attending physician. Interventions for undesirable weight loss shall be based on careful consideration. The analysis and recommendations will be sent to the attending physician for orders when there is a negative significant trend in weight loss.Facility Licensed/Registered Dietician/RD/LD Nutritionist Professional license documents V15 is the facility RD/LD, and her license expires 10/31/2027.R2's medical record documents R2 is on a regular diet and liquids.R2's medical record documents R2 was offered a snack for the month of March 2026 and documents R2 is unavailable most of the time, and when she was available she did not reject any snack offered off the snack cart.R2's medical record documents on 11/05/2025 R2 weighed 137 pounds, and on 04/08/2026 R2 weighed 122.4 pounds which is a 10.66% weight loss. BMI/Body Mass Index 21.01.R2's current care plan, edited 2/24/26, documents Nutritional risk indicator score is high at this time. Follow diet as ordered. Encourage good food/fluid intakes with meals.R2's LD/RD note by V15, dated 4/2/26, which was marked INVALID, documents Resident continues on Regular Diet/General diet, BMI-21.3 (lower end for age/height). Recommend weekly wts (weights) x4 weeks and offer an appetite stimulant. Offer the resident alternatives if eating less than 50% percent at meals. Encourage good oral intakes. Continue to monitor status. Consult (V15) LD/RD as needed.On 4/09/2026 at 10:20 AM, V14 Licensed Practical Nurse/LPN stated I am (R2's) nurse today. We haven't tried any (nutritional) supplements for her, she gets chocolate milk with her meals, she has had a three-pound weight loss in the past month, she does go to the dining room for meals, and she does sleep more.On 4/09/2026 at 11:25 AM, V2 Director of Nursing/DON stated I noticed (V15's) note was grayed out so she did not finish note and I have reached out to (V15). (R2) has had some weight loss and I have contacted her family.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review the facility failed to appropriately store oxygen nasal cannula when not in use and failed to ensure physician orders contained liter flow of oxygen to be administered for one (R43) of one resident reviewed for oxygen in a sample of 26. Findings include: The facility's policy Oxygen Administration last reviewed 3/10/26, documents not in its entirety, To administer oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues .16. When resident is not using the O2 (oxygen) cannula, store in cloth bags provided. Make sure cannula is dry before putting in cloth bag. Procedure: 3. Check physician order for liter flow. R43's facility face sheet documents R43's date of admission to facility was 1/21/25 and R43's diagnoses include but not limited to Chronic Obstructive Pulmonary Disease, unspecified, Chronic Diastolic (Congestive) Heart Failure, Shortness of breath.R43's physician orders dated 1/21/25 documents R43 has the following order, Titrate oxygen for pulse ox (oximetry) > (greater than) 89% (percent) consistently per NC (nasal cannula) every shift. No further orders for oxygen liter flow in R43's medical record. R43's current care plan documents that R43 has a diagnosis of COPD (Chronic Obstructive Pulmonary Disease) and SOB (Shortness of Breath) and to monitor respiratory status, oxygen saturation, and provide oxygen as ordered. On 4/07/2026 and 4/8/2026 R43's oxygen nasal cannula was observed not in use and to be draped over oxygen concentrator in room and not in a bag. On 4/07/2026 9:30 AM R43 is reclining back in his recliner and in no distress. R43 stated he wears oxygen at night when he goes to bed but unsure at what liter flow. On 4/08/2026 at 1:50 PM, V7 (Registered Nurse) stated that R43 wears his oxygen at night on 2 liters. Verified that R43's orders do not have a specific order for liter flow and when asked how staff would know what liter to start at V7 stated, I would start at 2 liters, but I'd have to check our policy to see if there is a set liter flow that we are supposed to start with. V7 also verified that oxygen nasal cannula should be in the cloth bag hanging on the oxygen concentrator and R43's was not. 04/08/2026 2:08 PM V2 (Director of Nursing) stated that if the physician orders do not specify a liter flow for oxygen and just reads to titrate then it would be standard of care to administer at 2 liters. V2 also verified that if the oxygen tubing/nasal cannula was not in use it should be kept in the bag on the concentrator but, (R43) is known to take his out sometimes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff performed hand hygiene, utilized appropriate Personal Protective Equipment (PPE), and properly cleaned and disinfected resident medical equipment during blood glucose monitoring and insulin administration for two of two residents (R4 and R28) reviewed for infection control practices and failed to ensure staff implemented appropriate infection prevention practices during incontinence care, including hand hygiene and glove changes, for one of two residents (R4) reviewed for incontinence care in the total sample of 26.Findings include:Merged Findings The facility's policy titled, Standard Precautions, dated 1/6/26, 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 PPE, safe injection practices, respiratory hygiene/cough etiquette, environmental cleaning and disinfection, and reprocessing of reusable resident medical equipment. Definition: You must wear gloves if you come into contact with blood, body fluids, or mucous membranes of any resident. Change gloves after contact with each resident. Wash your hands or use hand sanitizer each time you remove your gloves. The facility's Policy on Injections—Subcutaneous/Heparin, dated 7/8/25, documents, follow universal precautions when administering all injections. Wash your hands, apply disposable gloves, discard equipment properly in sharps container, dispose of gloves and alcohol wipe in infectious waste, and wash your hands. R4's medical record documents R4 admitted on [DATE] with diagnoses including Congestive Heart Failure; Pressure Ulcer of the Sacral Area and identifying R4 is frequently incontinent of bowel and bladder. On 4/7/26 at 12:05 PM, V5/Licensed Practical Nurse (LPN) was in dining room performing blood glucose monitoring and obtained R4's blood sample by fingerstick method without performing hand hygiene or donning gloves beforehand. V5 then placed blood-soiled test strip, alcohol pad, and blood glucose monitor inside the blood glucose monitor case used for multiple residents. V5 did not perform hand hygiene after obtaining R4's blood glucose level and moved R4's clean spoon sitting on dining room table by touching the spoon with V5's soiled hands. V5 then proceeded to administer insulin subcutaneous injection into R4's abdomen without performing hand hygiene or donning clean gloves. V5 did not perform hand hygiene after R4's insulin was administered. V5 then gathered case containing used supplies and soiled blood glucose monitor and placed case on top of medication cart. On 4/7/26 at 12:25 PM, V5/LPN stated V5 should have performed hand hygiene and put gloves on prior to performing fingerstick to obtain blood sample for blood glucose monitoring and before and after V5 administered insulin to R4. V5 confirmed V5 touched R4's clean spoon that was sitting on the dining room table with V5's soiled hands. I should have washed my hands before touching the clean spoon after I performed the (blood glucose check) for R4 without gloves on. V5 confirmed blood glucose monitor should have been cleaned and disinfected prior to putting monitor back in clean case. (continued on next page)

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	145704	A. Building B. Wing	04/10/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V5 stated the blood glucose monitor used for R4 is used for one other resident (R28). On 4/8/26 at 3:30 PM, V2/Director of Nursing confirmed V5 should have performed hand hygiene and applied gloves before V5 performed blood glucose check and administered insulin injection to R4. V2 stated hand hygiene should be performed by staff each time gloves are applied and removed. Hands should be washed with soap and water if they are soiled. The blood glucose monitor used for multiple residents should be cleaned and disinfected after each use and before the monitor is put back into its case. On 4/9/26 at 8:50am V10 and V11, CNAs/Certified Nursing Assistants provided incontinence care for R4. Throughout incontinence care, V10 did not perform hand hygiene or change gloves after removing R4's incontinence brief, or after cleaning R4's peri area and anal area and did not perform hand hygiene or change gloves before drying R4's peri areas and fitting R4 with a clean incontinence brief. During R4's incontinence care, V10 placed R4's soiled brief and the soiled washcloths on top of the under-pad on R4's bed. After providing the incontinence care, V10 picked up a large positioning wedge, wearing the same gloves and placed it behind R4's back and adjusted the coverlet over R4. After positioning R4, V10, then picked up the soiled towel, washcloths, and the soiled incontinence brief from R4's bed and put the brief in the trash receptacle in R4's room. V11 then removed his gloves, performed hand hygiene, and removed the trash bag containing soiled items, gloves and the soiled brief with his bare hands. V11 then tied the trash bag shut, without donning gloves, held the bag against his chest and left R4's room into the hallway with the bag held against his chest. On 04/10/26 at 9:25am, V1 DON/Director of Nursing verified hand hygiene and glove changes are to be done after incontinence care is done and before clean procedures are started, and a trash can should be placed so staff can dispose of soiled briefs are not placed on the resident's bed.