STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146011	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robings Manor Rhc	502 North Main Brighton, IL 62012

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** 32874 Based on observation, record review and interview the facility failed to properly identify, assess and treat pressure areas for 1 of 3 residents (R4) reviewed for pressure ulcers in the sample of 37. Findings include: 1. On 10/22/204 at 9:02AM during incontinent care surveyor requested skin check of R4's feet. R4's Right 1st, 2nd and 3rd toes all have wounds to top of toe. R4's right foot 1st toe circular open area with reddened are surrounding wound. Area approximate size end of pencil eraser. 2nd and 3rd toes areas are scabbed. No dressings or treatments present. On 10/23/2024 at 10:15AM V5, Licensed Practical Nurse (LPN) stated in regards to wounds on R4's toes they are just monitoring them. V5 stated R4 never wears shoes. R4's Treatment Administration Record (TAR) Dated 10/4/2024 documents scabs on 2nd and 3rd toes right foot and bottom of foot tx (treat) until healed q (every) shift. R4's record fails to document any measurement or treatments. R4's care plan dated 7/15/2024 documents, R4 high risk for pressure ulcer per skin risk assessment risk factors include decreased mobility and incontinence. R4's care plan documents intervention dated 7/15/2024 assess skin, if open or bruised areas, report to MD (Medical Doctor) and responsible party. R4's pressure sore risk assessment for predicting pressure ulcers dated 10/06/2024 documents a score of 15 with a score of 16 and less indicating high risk R4's Minimum Data Set (MDS) dated [DATE] documents R4 is at risk for developing pressure sores. On 10/23/24 at 11:45 AM V2, Infection Preventionist agreed R4's wounds were not documented on the wound log. R4 stated she would have R4 assessed by wound management. (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: 146011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Robings Manor Rhc		STREET ADDRESS, CITY, STATE, ZIP CODE 502 North Main Brighton, IL 62012	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Decubitus Care/Pressure Areas dated, revised 1/18 documents upon notification of skin breakdown the Quality Assurance (QA) form for Newly acquired skin conditions will be completed and forwarded to the Director of Nurses. The policy documents the pressure area will be assessed and documented on the Treatment administration record (TAR) wound documentation record. The policy documents document size, stage, site depth drainage and treatment, document the stages of the pressure ulcer, document the color , notify the physician for treatment order which should include, type of treatment, frequency, how to cleanse if needed. The policy documents documentation of the pressure area must occur upon identification and at least once each week on the TAR or wound documentation form. The policy documents nursing personnel are to notify dietary personnel of any pressure areas to seek nutritional support and monthly reviews by the registered dietitian. The policy documents when a pressure ulcer is identified additional interventions must be established and noted on the care plan in an effort to prevent worsening or re-occurring pressure ulcers.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 32874 Based on observation, record review and interview the facility failed to provide safe transfers for 4 of 8 residents (R7, R16, R17, and R18) reviewed for accidents in the sample of 37. Findings include: 1. On 10/22/2024 at 1:50 PM V11, Licensed Practical Nurse (LPN) placed an arm underneath R7's arm and physically assisted R7 from wheelchair to bed. V11 LPN did not use a gait belt for transfer. After treatment to R7's abdominal wound, V11 assisted R7 again and placed an arm underneath R7's arm and physically assisted R7 to his wheelchair from the bed without the use of a gait belt. R7's Care Plan, dated 9/19/2024, documents self-care deficit -needs supervision and/or poorly motivated to complete ADL's (Activities of Daily Living) related to: Total Brain Injury (TBI) sequelae as evidenced but needs supervision for Activities Daily Living (ADL's) to ensure appropriate completion and safety. R7's care plan intervention dated 9/19/2024 documents assist to transfer resident using 1 staff assist. Use gait belt for all hands on transfers from one surface to another. R7's fall risk assessment dated [DATE] documents score of 11 with score of 10 or more indicating high risk for falls. On 10/23/2024 at 8:39 AM V8, Certified Nursing Assistant (CNA) stated it is facility policy to use gait belt when assisting residents with transfers. V8 stated a gait belt is to be used with R7. 44967 2. R16's Admission Record, undated, documents R16 was admitted to the facility on [DATE] with diagnosis of Alzheimer's disease. R16's Care Plan, dated 7/10/24, documents R16 is dependent for ADLs. Interventions: Transfer R16 using mechanical device of (Mechanical Lift) and two staff members. Explain all procedures prior to starting. Advise R16 what is expected of her during the transfer. Reassure R16 of safety as needed. Keep hand on R16 to reassure of safety if needed. Ensure lift sheet is intact and correct size for R16. Place in wheelchair / Geri-chair / (Positioning Wheelchair) for positioning while up and all transport. R16's Minimum Data Set (MDS), dated [DATE], documents R16 has a severe cognitive impairment and is dependent on staff for all ADLSs. R16's mobility devices include wheelchair. R16 is dependent on staff for all transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/21/24 at 11:20 AM, V9, CNA, and V10, CNA, observed transferring R16 from her bed to her recliner chair for lunch. A full body mechanical lift sling was placed under R16, and the device was attached to the sling. V10 lifted R16 off her bed and over the side rail of the bed, while V9 was holding onto the chair in the middle of the room. V10 pulled R16 over to the recliner with R16 swinging freely in the air with no one holding onto her. R16 was then lowered to the recliner and disconnected from device. 3. R17's Admission Record, undated, documents R17 was admitted to the facility on [DATE] with diagnosis of Alzheimer's disease, Depressive disorder, and anxiety disorder. R17's Care Plan, dated 6/19/24, documents R17 is dependent for care. Interventions: R17 is not toileted due to being a total lift with full body mechanical lift device due to safety concerns. R17 is dependent on cares. Interventions: Toilet use: R17 is not toileted due to being a total lift with (Mechanical Lift) due to safety concerns. Transfer: Assist to transfer R17 using mechanical device of (full body mechanical lift) and two staff members. Explain all procedures prior to starting. Advise R17 what is expected of her during the transfer. Reassure resident of safety as needed. Keep hand on R17 to reassure of safety if needed. Ensure lift sheet is intact and correct size for R17. R17's MDS, dated [DATE], documents R17 has a severe cognitive impairment and is dependent on staff for all ADLs. R17's mobility devices include wheelchair. R17 is dependent on staff for all transfers. On 10/21/24 at 11:30 AM, V9, CNA, and V10, CNA, observed transferring R17's from her bed to her chair. A full body mechanical lift sling was already underneath R17. The lift device was brought over and attached to the sling without locking the device's wheels, and V10 lifted R17 off her bed while V9 was holding onto R17's geri-chair approximately four to six feet away. V10 then pulled R17 over to the geri-chair with R17 swinging freely in the air with no one holding onto her. R17 was then lowered to the chair. 4. R18's Admission Record, undated, documents R18 was admitted to the facility on [DATE] with diagnosis of Cerebral Vascular Accident (CVA), Kyphoscoliotic deformity of spine, Thoracic corpectomy, and Depression. R18's Care Plan, dated 5/15/24, documents R18 is dependent for ADLs, and is a high fall risk and requires (Mechanical Lift) lift transfer. Interventions: Transfer R18 using mechanical device of (Mechanical Lift) and two staff members. Explain all procedures prior to starting. Advise R18 what is expected of her during the transfer. Reassure R18 of safety as needed. Keep hand on R18 to reassure of safety if needed. Ensure lift sheet is intact and correct size for R18. Place in wheelchair / Geri-chair / (Positioning Wheelchair) chair for positioning while up and all transport. R18's MDS, dated [DATE], documents R18 is cognitively intact and is dependent on staff for ADLs. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/21/24 at 11:06 AM, V9, CNA, and V10, CNA, transferring R18 from her bed to a wheelchair. The lift sling was placed under R18, the full body mechanical lift device was brought into the room and attached to the sling without locking the wheels. V10 lifted R18 off her bed while V9 was holding onto R18's wheelchair approximately six feet away. V10 had to lift R18 high enough in the air to go over a side rail on the bed. V10 then pulled R18 from the bed and over to R18's wheelchair, allowing R18 to swing freely in the air with no one holding onto her. R18 was then lowered to the wheelchair and the device disconnected. On 10/23/24 at 11:22 AM, V8, CNA, stated When doing a (full body mechanical lift device) transfer, you would first lock the wheelchair and the device, attach the straps and double check them to make sure they are secure, then one person would operate the device and the other person will hold and guide the resident during the transfer. The facility policy Transfer belts/gait belts dated, revised 01/02 documents to promote safety in transferring and ambulating residents, a gait belt is utilized when deemed appropriate by nursing staff or therapy staff. The policy documents a gait belt is used if indicated on care plan and/or kardex. The Facility's Mechanical Lift Policy, dated 10/30/08, documents The mechanical lift may be used to lift and move a resident with limited ability during transfer while providing safety and security for residents and nursing personnel. 8. Position lift at side of bed. Lock wheels on lift. 12. The guidance strap may be used to guide the resident into a proper position while resident is being lowered.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44967 Based on interview, observation, and record review, the facility failed to provide complete incontinent care and urinary catheter care for 6 of 6 residents (R4, R5, R9, R10, R12, R17) reviewed for incontinent care and catheter care in the sample of 37. Finding include: 1. R9's Admission Record, undated, documents R9 was admitted to the facility on [DATE] with diagnosis of Vascular Dementia. R9's Care Plan, dated 9/27/24, documents R9 is dependent on staff for ADLs (Activities of Daily Living). R9 has bladder incontinence. Interventions: Clean peri-area with each incontinence episode, check every two hours, PRN (as needed), and as required for incontinence, wash, rinse, and dry perineum, change clothing PRN after incontinence episodes. R9's Minimum Data Set (MDS), dated [DATE] documents R9 has a severe cognitive impairment and is dependent on staff for ADLs. R9 is frequently incontinent of bowel and bladder. On 10/22/24 at 8:52 AM, R9 observed getting incontinence care from V9, Certified Nursing Assistant/CNA, and V14, CNA. Both CNAs donned gloves with no hand hygiene done prior to care. R9's incontinence brief was unfastened and tucked between his legs. V14 used a wet wipe and wiped once downward between R9's legs, changed her gloves with no hand hygiene performed. R9 was rolled over with feces noted in his brief. V14 used wet wipes and wiped R9's anal area several times with no cleaning of R9's buttock, then used the same soiled gloves to roll R9 to his right side where she wiped R9's left buttock. R9 was rolled to his back side and his brief was fastened. There was no cleaning of R9's penis, including pulling back his foreskin, no cleaning of R9's bilateral groins, and no cleaning of R9's right buttock. 2. R10's Admission Record, undated, documents R10 was admitted to the facility on [DATE] with diagnosis of Cerebral Vascular Accident (CVA), Hemiplegia, Dysphagia/Aphasia, Human Immunodeficiency Virus (HIV), Depression, and Leukoencephalopathy, R10's Care Plan, dated 8/9/24, documents R10 is dependent for ADLs, has bladder incontinence. Interventions: Clean peri (Perineal) -area with each incontinence episode, check every two hours and PRN, wash, rinse, and dry perineum, change clothing PRN after incontinence episodes. R10's MDS, dated [DATE], documents R10 has a moderate cognitive impairment and is dependent on staff for ADLs. R10 is always incontinent of both bowel and bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/22/24 at 12:22 PM, V9, CNA, and V14, CNA, performed incontinent care on R10. V9 unfastened R10's two incontinence briefs which appeared very saturated with a strong smell of urine. V9 used wet wiped and wiped R10's bilateral groins, then rolled R10 over to his left side, showing feces in his brief and anus. V9 used the soiled brief to wipe the feces off R10's anus and tucked the soiled brief under R10. V9 then used wet wipes and wiped R10's anal area and right buttock. R10 was turned to his right side and V14 pulled the soiled brief/bed pad out from under R10, and a new brief and bed linen tucked under him. There was no cleaning or wiping of R10's penis or left buttock, and no drying of R10 at any time. On 10/22/24 at 12:05 PM, V2, Director of Nursing, stated (R10) does refuse to get out of bed a lot, but we should be checking him for incontinence every two hours. When told that R10 has not been checked for incontinence since this morning, V2 stated Well that is not acceptable, and they need to get him cleaned up before lunch. Thank you for letting me know. On 10/23/24 at 11:24 AM, V8, CNA, stated I always check my residents every two hours for turning and incontinence. Usually, I get them up before breakfast, get them back to bed after breakfast, then get them up again before lunch and back to bed after lunch. I check them for incontinence each time I get them up or put them back to bed. 3. R12's Admission Record, undated, documents R12 was admitted to the facility on [DATE] with diagnosis of Multiple Sclerosis, Neurogenic bladder, Dysphagia, and Depression. R12's Care Plan, dated 7/1/24, documents R12 is dependent for ADLs, requires one to two assists for peri-care. R12 has a urinary catheter. Interventions: Catheter care every shift. R12's MDS, dated [DATE], documents R12 is cognitively intact and is dependent on staff for all ADLs. R12 has urinary catheter in place and is always incontinent of bowel. On 10/22/24 at 10:35 AM, R12 had just returned from shower and placed back in bed. R12 has a 20-30g (gage) urinary catheter in place with three ports. One port goes to urinary bag hanging on the side of her bed, one port goes to a leg bag secured to R12's left leg, and one port is for flush. R12 stated when the nurse changed her catheter the last time, they wanted a bigger one and this was the only one they had available. V14, CNA, was in the room to do catheter care on R12. V14 donned gloves with no hand hygiene done prior to care. V14 wiped twice down the middle of R12's vagina, emptied the urinary bag hanging from the bed, and used the same soiled gloves to attach the catheter tubing to the leg bag strap. There was no wiping of the actual urinary catheter coming out R12's urethra. There was no hand hygiene seen done before, during glove changes, and after care. 4. R17's Admission Record, undated, documents R17 was admitted to the facility on [DATE] with diagnosis of Alzheimer's disease, depressive disorder, and anxiety disorder. R17's Care Plan, dated 6/19/24, documents R17 is dependent for care. Interventions: R17 is not toileted due to being a total lift with (full body mechanical lift) due to safety concerns. R17 has bladder incontinence. Interventions: Clean peri-area with each incontinence episode, check every two hours and as required for incontinence, wash, rinse, and dry perineum, change clothing PRN after incontinence episodes. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R17's MDS, dated [DATE], documents R17 has a severe cognitive impairment and is dependent on staff for all ADLs. R17 is always incontinent of bowel and bladder. On 10/22/24 at 9:20 AM, V9, CNA, and V14, CNA, performed incontinent care for R17. Supplies, including plastic bags and a container of wet wipes seen lying on the bed. R17 was rolled over and her pants pulled down, showing her incontinence brief was saturated. V9 changed her gloves with no hand hygiene done. R17's brief was unfastened and tucked between her legs, V14 used wet wipes and wiped twice down the middle of R17's vagina without spreading or wiping the labia, and without wiping either groin. R17 was turned to her right side and V14 wiped R17's anal area and did not wipe R17's buttock. A clean brief was tucked under R17 and fastened. There was no drying of the R17 at any point during incontinence care. 32874 5. On 10/22/24 at 9:02AM during incontinent care, R4's incontinence brief was removed by V8, CNA. R4 incontinent of stool in brief. R4's brief was removed. V8 took sanitizing wipes and wiped down right groin then obtained another wipe and did the left groin. V8 pulled foreskin back and R4 stated Don't do that. V8 did not cleanse under scrotum or dry R4. R4's Care Plan, dated 7/31/2024 documents R4 has urinary incontinence related to incontinence of bowel and bladder. unable to use toilet. care plan documents the following interventions dated 7/13/2024; apply house stock barrier cream prn after incontinent care report to nurse and change for any skin concerns, check, and change padding and give proper hygiene before, meals/after meals, upon rising upon request before retiring for the evening, after napping and prn for incontinence. 6. On 10/22/24 at 8:46AM during incontinent care, V13, CNA removed R5's wet incontinence brief. V13 then rolled R5 back on pad., V13 put soiled brief in plastic bag. V13 started cleansing R5's left groin then R5's right groin. V13 separated R5's labia and wiped front to back. V13 did not dry R5 after cleansing R5 with cleansing wipes. V8 assisted R5 on right side after cleansing R5 buttocks and rectal area with cleansing wipes. V8 and V13 did not dry R5. R5's Care Plan revised 7/18/2024 documents R5 has alteration in bladder as related to incontinence. R5's care plan documents intervention revised 7/18/2024 documents incontinent: toilet and or change padding and give proper hygiene before/after meals upon rising, before retiring before the evening, after napping and prn for incontinence. R5's Minimum Data Set (MDS) dated ,d+[DATE] documents R5 is always incontinent of bowel and bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Perineal Cleansing Policy, dated 12/2017, documents washcloth and towel, soap and other cleansing agent, gloves wash basin, plastic bag. The policy documents female without catheter to wash pubic area including upper inner aspect of both thighs and frontal portion of perineum, use long strokes from the most anterior down to the base of the labia, after each stroke refold the cloth to allow use of another area. follow same sequence for rinsing area, place soiled items in plastic bag and dry thoroughly. The policy documents wash peri-anal area thoroughly with each stroke beginning at the base of the labia and extending up over the buttocks, dry thoroughly, remove gloves and wash hands with soap and water, apply new incontinent product, clothes or reposition comfortably. wash hands with soap and water, cleansing gel. The policy documents male without catheter wash pubic area, including upper inner aspect of both thighs as well as the penis and scrotum, wash area under scrotum, rinse area in same sequence, retract the foreskin and wash to remove secretions, rinse area in same sequence. Dry carefully, remembering to draw foreskin of the uncircumcised male back over the head of the penis. Dry thoroughly, remove gloves and wash hands with soap and water, cleansing gel. apply clean incontinent product, clothes or reposition resident comfortably, wash hands with soap and water, cleansing gel. Note: the basic infection control concept for peri-care is to wash from the cleanest to the dirtiest area and remember to change or remove gloves and wash hands when going from working with contaminated items to clean items. The Facility's Catheter Care Policy, dated 3/15/23, documents Catheter care is provided daily and as needed to all residents who have an indwelling catheter to reduce the incidence of infection. Equipment: 1. Soap and Water. 2. Alternative cleansing product. 3. Washcloth. 4. Towel. 5. Basin. 6. Gloves. 7. Cleansing product will be used if not using soap and water. Females: 1. Wash your hands. 2. Apply clean gloves. 3. Separate the labia. 4. Wash perineal area with warm soap and water or cleansing product. 5. Wash from front to back. 6. Gently remove any secretions or encrustation around the urethral opening. 7. Wash the catheter tubing from the opening of the urethra four inches or farther if needed. 8. Rinse and dry the area well. 9. Remove your gloves. 10. Wash your hands.

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.

44967

Based on interview and record review, the facility failed to provide a Registered Nurse (RN) for at least eight hours a day for seven days a week and failed to have a Director of Nursing (DON) on a full-time basis. These failures have the potential to affect all 29 residents residing in the facility.

The findings include:

On 10/23/24 at 1:20 PM, V2, Director of Nursing, DON, stated We only have one RN, and she works 6:00 PM to 6:00 AM. We have a couple more, but they mainly only work once or twice a month.

On 10/24/24 at 10:25 AM, V1, Administrator, stated I have had the DON position posted for a long time and have only had 3 applicants so far. I thought I had one picked out, but she changed her mind and went elsewhere. I know it has been close to a year now without a DON but hoping to fill it soon.

On 10/24/24 at 10:30 AM, V19, Licensed Practical Nurse (LPN), stated I usually work with LPNs because there isn't very many RN's. We always have the managers up front to help us. I didn't realize that they were not RNs.

10/24/24 at 10:55 AM, V5, LPN, stated We only have one full time RN here, and we have two PRN (as needed) RNs, but they rarely work.

The facility's Nursing Schedule for the past four months were reviewed. There is only one RN, V30, on the schedule that works full time. This RN works midnight shift from 6:00 PM until 6:00 AM, therefore, does not cover the facility for eight hours per day. There are two other RNs listed on the schedules with one being PRN and minimal workdays seen. The Facility's Nursing Schedule, dated October 2024, documents V30 worked on 10/2, 10/3, 10/7, 10/8, 10/11, 10/12, 10/13, 10/17, 10/19, 10/20 and 10/22/24. There was no RN at all on 10/5 and 10/6/24.

The Facility's Nurse Staffing Policy, undated, documents It is the policy of (The Facility) to provide sufficient licensed and unlicensed nursing staff on each shift of the day to attain or maintain the highest practical physical, mental, and psychosocial wellbeing of each resident. Nurse staffing shall be based upon resident evaluation by the Administrator and Director of Nursing as specified by the (State Agency). Each skilled care resident shall receive at least 3.8 hours of nursing and personal care each day and 2.5 hours of nursing and personal care each day for a resident needing intermediate care. A minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by Registered Nurses. Registered Nurses and Licensed Practical Nurses employed by a facility in excess of these requirements may be used to satisfy the remaining 75% of the nursing and personal care time requirements. Licensed Nurses are required to be licensed by the State in which they are practicing. Copies of current licenses shall be displayed in the facility. No person may provide direct resident care without certification and records check.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robings Manor Rhc	502 North Main Brighton, IL 62012

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Long-Term Care Facility Application for Medicare and Medicaid, dated 10/21/2024, documents the total number of residents in the facility is 29.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 44967 Based on observation, interview and record review, the facility failed to ensure the daily nursing staff posting was current for 4 of 4 days of the survey. This failure has the potential to affect all 29 residents residing in the facility. The Findings Include: On 10/23/24 at 1:00 PM, V21, Licensed Practical Nurse (LPN)/Minimum Data Set (MDS) Nurse, stated The staffing sheet used to be posted on the wall. I don't know where it went. It doesn't look like we have one posted anymore. On 10/24/24 at 10:55 AM, V5, LPN, stated I know there used to be a staffing and daily census sheet hanging by the time clock by the front door, but I haven't seen it in a while. On 10/23/24 through 10/24/24, there was no staffing information posted anywhere in the facility. On 10/24/24 at 11:45 AM, V1, Administrator, stated We don't have a policy on posting staffing information. The Long-Term Care Facility Application for Medicare and Medicaid, dated 10/21/2024, documents the total number of residents in the facility is 29.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 35156 Based on observation, interview and record review, the facility failed to check and maintain food temperatures during meal service. This has the potential to affect all 29 residents living in the facility. Findings include: On 10/22/2024 at 11:34 AM, V3, [NAME] took the hamburgers out of the oven but did not take any temperatures on them. She then proceeded to put the hamburgers directly into the blender and make purees. On 10/22/2024 at 11:42 AM, a test sample was taken on the pizza burger, and it was not hot in temperature and taste. On 10/22/2024 at 11:44 PM, V3, after she had finished pureeing the pizza burgers, put them in a metal pan. At no point, did V3 take the food temperatures and ensure it was at 165 degrees. V3 then put the puree pizza burgers on the steam table without ensuring it reached 165 degrees Fahrenheit. On 10/22/2024 at 11:46 AM, V3 took the temperatures of the pizza burger and stated they were not within range and put them back in the oven. V3 stated the burger was at 100 F. On 10/22/2024 at 11:47 AM, the pizza burgers were in the oven, but the oven was not turned on, and the oven was not hot to the touch. On 10/22/2024 at 11:49 AM, V3 took the pizza burgers out of the cold oven and did not retake the temperatures. V3 sat the cookie sheet on top of the steam table and did not place them inside or in a tub inside the steam table. On 10/22/2024 at 11:50 AM, V3 took out large industrial metal pan from the cold oven and sat it on the countertop. V3 did not take any temperatures of the item. The pan was not hot to the touch. On 10/22/2024 at 11:52 AM, V3 stated the metal pan contained the mechanical pizza meat. On 10/22/2024 at 12:24 PM, after the last lunch tray had been served, food temperatures were taken on the steam table and countertop with a calibrated metal thermometer. The mechanical meat was in a pan on the countertop. The following temperatures were taken: Pureed pizza burger 126.0 Fahrenheit (F), broccoli 72.0 F, pizza burger 90.0 F. On 10/22/2024 at 12:28 PM, V3, [NAME] stated she would expect all the holding food in the steam tables to be at least 135 degrees F or higher. On 10/23/2024 at 9:41 AM, V15, Dietician stated, I would expect all food to be dated and labeled. All hot food on the steam table should be at least 135 degrees Fahrenheit or higher. If the temperature is lower than 135 degrees, this could be harmful because the temperatures can get in the danger zone and bacteria can grow and thrive at that temperate which could be harmful to the residents. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident Council Meeting Minutes dated 2/14/2024, Food is not hot coming out. Resident Council Meeting Minutes dated 5/22/2024 documents, Some of the meat is hard and cold. Resident Council Meeting Minutes dated 6/25/2024 documents, Cold Food on evenings. Resident Council Meeting Minutes dated 7/18/2024 documents, Food coming out cold. Resident Council Meeting Minutes dated 8/5/2024 documents, Food coming out cold at times. Resident Council Meeting Minutes dated 9/6/2024 Food is not hot as it should be and cold food room temperature and not cold. The Puree Recipes Menu documents all purees to be reheated to 165 degrees F and hold for service at 135 degrees F or above. R167's Grievance dated 10/13/2020 the food is never hot, and the meat is tough to cut and chew. No flavor on food either. On 10/22/2024 at 12:35 PM, V15, Dietary Manager stated she would expect all food to be held at 135 degrees or higher. The Monitoring Food Temperature for Meal Service Policy 2013 edition documents, Food temperatures will be monitored daily to prevent food borne illness and ensure foods are served at palatable temperatures. Prior to serving a meal, food temperatures will be taken and documented for cold and hot foods to ensure proper serving temperatures. If the serving/holding temperatures of a hot food item is not at 135 degrees F or higher when checked, they will be reheated to at least 165 degrees for a minimum of 15 seconds, only once and discarded or consumed within two hours. The CMS 671 Long Term Care Facility Application for Medicare and Medicaid form dated 10/21/2024 documents the facility has 29 residents.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 35156 Based observation, interview, and record review the Facility failed to ensure food was prepared and appropriate to meet resident's needs for 4 of 4 residents (R17, R20, R21 and R28) reviewed for pureed diets in the sample of 29. Findings include: On 10/22/2024 at 11:01 AM, V3, [NAME] stated she was getting ready to prepare the pureed and mechanical diets. On 10/22/2024 at 11:02 AM, V3 stated she had six residents in the facility that were on pureed diets. On 10/22/2024 at 11:03 AM, V3 began preparing the pureed broccoli. V3 was not following a recipe and there was no book opened. V3 placed 8 cups of broccoli in the food processor. V3 added a brown liquid that was already made to the broccoli. The food processor was crowded and full. On 10/22/2024 at 11:08 AM, V3 stated she was done with the broccoli puree and provided a spoon for a taste test. The broccoli was very thick in appearance. V3 also stated the thickener was in the brown liquid that she had made up earlier and her thickener was in the liquid. On 10/22/2024 Inside the puree were small pieces of broccoli. The consistence was not smooth and contained small particles of broccoli. The Puree Broccoli instructions documents Measure the number of puree portions required from the regular recipe (1/2 cup). Drain and reserve cooking liquid. Add to food processor and process to fine consistency. 6 servings 4 ounces, 1/2 teaspoon chicken base, 6 fluid ounces of water, and 1 1/2 tablespoons of commercial thickener. On 10/23/2024 at 9:41 AM, V15, Dietician stated, I would expect all purees to be smooth, with no lumps and the consistency of pudding. They are on these diets for a reason. Lumps would not be good, choking hazard. The Facility provided a list of residents on puree diets and R17, R20, R21 and R28 were all listed as receiving pureed diets. The Method of Pureeing Food Policy with a revision date of 10/12 documents, It is the policy of (Facility) to ensure residents that are on purred diets receive food that is prepared in an acceptable manner to enhance tolerance and intake and provide consistency of preparation. Blend to a smooth, pudding like consistency. Add thickener as needed for proper consistency. [NAME] or designee must sample small bite of puree item with disposable spoon to ensure smooth consistency. Texture should be smooth, pudding-like-consistency.

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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. 35156 Based on observation, interview, and record review the facility failed to ensure food was stored and prepared in a manner which prevents potential contamination. This has the potential to affect all 29 residents living in the facility. Findings include: On 10/22/2024 at 8:42 AM, during the kitchen visit, upon opening the lid of the ice machine, the grooves of the top of the machine are brown in color and needed cleaning. On the side of the ice machine was a schedule for ice cleaning and initials but the item was blank. No initials were documented for the ice machine ever being cleaned. On 10/22/2024 at 8:44 AM, V3, [NAME] stated she was not the Dietary Manager. She also stated she was not sure when the last time the ice machine was cleaned. On 10/22/2024 at 8:47 AM, in the refrigerator, there was a block of orange cheese slices. Approximately 24 slices were wrapped in plastic with no dates and or labels. On 10/22/2024 at 8:48 AM, there was an open container of bologna with a use by date of 9/27/2024. On 10/22/2024 at 8:49 AM, the dry multi-colored cereal in a clear container was labeled 8/30/2024. On 10/22/2024 at 8:47 AM, in the walk-in refrigerator the fan on the side of the walk in was dusty and in need of cleaning. The fan was blowing. On 10/22/2024 at 8:48 AM, The door handle to open the freezer is broken and does not work properly. The seal on the side of the door, is broken and the door does not shut properly. On 10/22/2024 at 8:49 AM, in the walk-in freezer there was a crate sitting directly on the floor. In the crate was a large industrial size amount of frozen vegetables sitting in the crate directly on the floor. On 10/22/2024 at 8:52 AM, there was a black hose coming from the wall that was covered with two to three inches of solid ice. These ice crystals and formation were forming on a 13.5-pound box of 72 count donuts, and a 30 lb. (pound) box of French fries. On 10/22/2024 at 8:54 AM, V3 had a rag on the counter in the kitchen and she had one glove on her right hand. She picked up the rag and wiped down the counter. The rag was left on the counter. On 10/22/2024 at 11:05 V4, Dietary Aide, was cleaning dishes. V4 had a beard and was not wearing a hair net over his beard. On 10/22/2024 at 11:07 PM, V4 stated, No, I did not have a hairnet on. I know I am supposed to have a hairnet on my beard. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/22/2024 at 11:09 AM, V3 was making cake puree and after she had finished, she picked up the same rag and wiped down the counter again. On 10/22/2024 at 11:10 AM, V3 had sliced the cake and covered it with a plastic cover and then placed the dirty knife on top of the clean cake container. On 10/22/2024 at 11:18 AM, V3, left the tray line and went into the freezer and came back and did not wash or disinfect her hands. On 10/22/2024 at 11:20 AM, V3 was touching the hamburgers with her gloved hands and placing them on the buns. V3 was wearing a glove that had been cross-contaminated and did not wash or disinfect her hands. On 10/22/2024 at 11:58 AM, The Freezer Log posted outside of the freezer documents the following temperatures: 10-14-2024, 11 degrees Fahrenheit (F), 10/15/2024, 12 degrees F, 10/16/2024, 11 degrees F and 10/17/2024 12 degrees F. On 10/22/2024 at 12:03 PM, V15, Dietary Manager stated, It has been a while since the ice machine had been cleaned. I see the schedule on there that is blank, and I could not tell you the last time it has been cleaned. We thought maintenance was supposed to clean it. I see the brown stain and I would expect the ice machine to be clean. I would expect (V4) to be wearing a hair net over his beard. We have been having issues with the freezer for about two months now. We were having issues with the freezer keeping temperatures. I know the handle of the freezer is not closing and the seal is not good. I thought it was fixed. This is the first time I am aware of the ice building up in the freezer but knew the door was not closing properly. I expect all items to be dated and labeled and I expect all food to be off the floor at least six inches and food sitting on the steam table to be at least 135 degrees Fahrenheit (F). The Storage Policy dated 10/17 documents, The Ice Machine should be kept clean at all times. It should be kept within a supervised area. The ice should be inspected for cleanliness when serviced. All ice in the machine should be discharged if found with dirt or debris. The ice machine is cleaned and sanitized on a regular basis by the Maintenance of Dietary Department or designated. (See Ice Machine Cleaning Log). Also refer to the manufacture's cleaning procedure and recommendations. Delime the machine according to the manufacture's recommendations or per need based on water hardness. The Storage Policy with a revision date of 6/06 documents, It is the policy of (Facility) that food shall be stored on shelves in areas that provided the best preservation. Food shall be stored at the proper temperate and for appropriate lengths of time to protect quality of food and food cost. Shelves in all areas shall be kept at least 6 inches off the floor and 18 inches from the ceiling to allow for proper ventilation and sanitation. Store leftovers in covered, labeled, and dated containers under refrigeration or frozen. When using only part of the product, the remining product should be in the original package or airtight container and labeled and dated. The CMS 671 Long Term Care Facility Application for Medicare and Medicaid form dated 10/21/2024 documents the facility has 29 residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on observation, interview, and record review, the facility failed to perform hand hygiene during meal assistance, medication administration, incontinent and wound care and failed to wear personal protective equipment (PPE) to prevent the spread of infection for 14 of 16 residents (R5, R7, R9, R10, R12, R15, R16, R17, R20, R21, R23, R26, R84, R284) reviewed for infection control in the sample of 37. Findings include: 1. On 10/22/24 at 8:00 AM, during breakfast observation R16, R21, R5, and R84 were being assisted by V9, Certified Nursing Assistant (CNA), and V12, CNA and were at the same table. V9 and V12 sat between the residents feeding one after another on each side of them with no hand hygiene performed before, in between, or after assisting the residents. At another table, R20, R17, and R23 were being assisted by V8, CNA, and V13, CNA. V8 and V13 sat between the residents feeding one after another on each side of them with no hand hygiene performed before, in between, or after assisting the residents. On 10/23/24 at 11:20 AM, V1, Administrator stated The staff need to follow the hand hygiene policy when caring for the residents and when providing feeding assistance. On 10/24/24 at 10:34 AM, V7, CNA, stated If I am assisting residents with meals, I make sure I do hand hygiene before assisting them and in between each resident. 2. On 10/22/24 7:30 AM, V11, Licensed Practical Nurse (LPN) was seen passing medications to R84, R26, R15, and R284, with no hand hygiene performed before, in between residents, or after med pass. 3. R9's Admission Record, undated, documents R9 was admitted to the facility on [DATE] with diagnosis of Vascular Dementia. R9's Care Plan, dated 9/27/24, documents R9 is dependent on staff for ADLs (Activities of Daily Living). R9 has bladder incontinence. Interventions: Clean peri (Perineal)-area with each incontinence episode, check every two hours, PRN (as needed), and as required for incontinence, wash, rinse, and dry perineum, change clothing PRN after incontinence episodes. R9's Minimum Data Set (MDS), dated [DATE], documents R9 has a severe cognitive impairment and is dependent on staff for ADLs. R9 is frequently incontinent of bowel and bladder. On 10/22/24 at 8:52 AM, R9 was seen getting incontinence care from V9, CNA, and V14, CNA. V9 and V14 donned gloves with no hand hygiene done prior to care. R9's incontinence brief was unfastened and tucked between his legs. V14 used a wet wipe and wiped once downward between R9's legs, changed her gloves with no hand hygiene performed. R9 was rolled over with feces noted in his brief. V14 used wet wipes and wiped R9's anal area several times with no cleaning of R9's buttock, then used the same soiled gloves to roll R9 to his right side where she wiped R9's left buttock. R9 was rolled to his back side and his brief was fastened. V9 and V14 failed performed hand hygiene after care was performed and before leaving the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. R10's Admission Record, undated, documents R10 was admitted to the facility on [DATE] with diagnosis of Cerebral Vascular Accident (CVA), Hemiplegia, Dysphagia/Aphasia, Human Immunodeficiency Virus (HIV), Depression, and Leukoencephalopathy, R10's Care Plan, dated 8/9/24, documents R10 is dependent for ADLs, has bladder incontinence. Interventions: Clean peri-area with each incontinence episode, check every two hours and PRN, wash, rinse, and dry perineum, change clothing PRN after incontinence episodes. R10's MDS, dated [DATE], documents R10 has a moderate cognitive impairment and is dependent on staff for ADLs. R10 is always incontinent of both bowel and bladder. On 10/22/24 at 12:22 PM, V9, CNA, and V14, CNA, was seen performing incontinent care on R10. Both CNAs donned gloves with no hand hygiene done prior to care. V9 unfastened R10's two incontinence briefs which appeared very saturated with a strong smell of urine. V9 used wet wipes and wiped R10's bilateral groins, then rolled R10 over to his left side, showing feces in his brief and anus. V9 used the soiled brief to wipe the feces off R10's anus and tucked the soiled brief under R10. V9 then used wet wipes and wiped R10's anal area and right buttock. R10 was turned to his right side and V14 pulled the soiled brief/bed pad out from under R10, and a new brief and bed linen tucked under him. There was no cleaning or wiping of R10's penis or left buttock, and no drying of R10 at any time. Both CNAs doffed gloves with no hand hygiene performed prior to leaving the room. On 10/23/24 at 11:20 AM, V1, Administrator stated The staff need to follow the hand hygiene policy when caring for the residents. On 10/23/24 at 11:23 AM, V8, CNA, stated Hand hygiene should be done before and after resident care. When doing peri-care, your gloves should be changed when soiled and your hands should be washed when changing gloves. 5. R12's Admission Record, undated, documents R12 was admitted to the facility on [DATE] with diagnosis of Multiple Sclerosis, Neurogenic bladder, Dysphagia, and Depression. R12's Care Plan, dated 7/1/24, documents R12 is dependent for ADLs, requires one to two assists for peri-care. R12 has a urinary catheter. Interventions: Catheter care every shift. R12's MDS, dated [DATE], documents R12 is cognitively intact and is dependent on staff for all ADLs. R12 has urinary catheter in place and is always incontinent of bowel. There is a Enhanced Barrier Precautions (EBP) sign posted on R12's door with no Personal Protective Equipment (PPE) seen at the entrance to the room or in the room. On 10/22/24 at 9:25 AM, when asked about R12's Enhanced Barrier Precaution (EBP) sign on R12's door and the wearing of PPE, V14, CNA, stated I don't know why (R12) is on precautions or what PPE (Personal Protective Equipment) I'm supposed to be wearing. On 10/22/24 at 9:30 AM, when asked about the EBP sign on R12's door, V2, Director of Nursing (DON), stated (R12) is on that because of her urinary catheter. When asked where the PPE is located. V2 stated It should be outside the door. I know it was there at one time, but I don't know where it is now. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/22/24 at 3:15 PM, R12 stated The staff only wore masks and gowns when COVID was around. They don't wear it anymore. They don't wear it when they do my wound care or take care of my catheter. On 10/22/24 at 10:35 AM, R12 had just returned from shower and placed back in bed. R12 has a 20-30g urinary catheter in place with three ports. One port goes to urinary bag hanging on the side of her bed, one port goes to a leg bag secured to R12's left leg, and one port is for flush. R12 stated when the nurse changed her catheter the last time, they wanted a bigger one and this was the only one they had available. R12 stated she has not had any UTIs lately. V14 was in the room to do catheter care on R12. V14 donned gloves with no hand hygiene done prior to care. V14 did not wear a gown when providing R12's care. V14 wiped twice down the middle of R12's vagina, emptied the urinary bag hanging from the bed, and used the same soiled gloves to attach the catheter tubing to the leg bag strap. There was no wiping of the actual urinary catheter coming out R12's urethra. There was no hand hygiene seen done before, during glove changes, and after care. 6. R17's Admission Record, undated, documents R17 was admitted to the facility on [DATE] with diagnosis of Alzheimer's disease, Depressive disorder, and anxiety disorder. R17's Care Plan, dated 6/19/24, documents R17 is dependent for care. Interventions: R17 is not toileted due to being a total lift with (full body mechanical lift) due to safety concerns. R17 has bladder incontinence. Interventions: Clean peri-area with each incontinence episode, check every two hours and as required for incontinence, wash, rinse, and dry perineum, change clothing PRN after incontinence episodes. R17's MDS, dated [DATE], documents R17 has a severe cognitive impairment and is dependent on staff for all ADLs. R17 is always incontinent of bowel and bladder. On 10/22/24 at 9:20 AM, V9 and V14, performing incontinence care on R17. V9 and V14 donned gloves with no hand hygiene done prior to. Supplies, including plastic bags and a container of wet wipes seen lying on the bed. R17 was rolled over and her pants pulled down, showing her incontinence brief was saturated. V9 changed her gloves with no hand hygiene done. After R17's incontinence care, V9 and V14 doffed their gloves with no hand hygiene performed before leaving the room. 32874 7. On 10/21/2024 at 8:30 AM enhanced barrier precaution sign was posted on R7's room door. No Personal Protective Equipment (PPE) observed in hallway or in R7's room. Enhanced Barrier Precaution Sign on door documents everyone must: clean their hands , including before and when leaving room. The sign documents providers and staff must also wear gloves and a gown for the following high contact resident care activities, wound care: any skin opening requiring a dressing. On 10/22/24 at 10:38 AM V11, Licensed Practical Nurse (LPN) stated R7 is on enhanced barrier precautions for an abdominal wound. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/22/24 at 02:03 PM, V11 did not sanitize hands , donned gloves and gown and entered R7's room with wound treatment supplies. V11 placed supplies on overbed table. V11 with same gloves on, closed R7's room door, then went and closed R7's curtain V11 then physically assisted R7 to bed. With the same gloves, V11 lifted R7's shirt and removed dressing touching wound bed to remove gauze. R7 has midline wound pink with small amount of pink tinged drainage on dressing. R7 stated wound vac (vacuum) was removed today at the doctor office. After V11 removed R7's dressing, V11 doffed gloves, and donned gloves. V11 did not sanitize hands prior to donning gloves V11, LPN cleansed wound with sterile water applied wet to dry dressing and covered with gauze and tape. On 10/24/2024 at 9:04 AM V5, Licensed Practical Nurse (LPN) stated when entering a enhanced barrier precaution room you ae to sanitize hand prior to entering the room and donning gloves. V5 stated gloves are to be changed after touching surfaces prior to cleansing a wound. 8. On 10/22/2024 at 8:46AM during incontinent care V13, CNA did not sanitize hands prior to donning gloves, or after doffing gloves when cleansing R5. R5's care plan dated, revised 7/18/2024 documents R4 has alteration in bladder as related to incontinence. R5's care plan documents intervention dated, revised 7/18/2024 documents incontinent: toilet and or change padding and give proper hygiene before/after meals upon rising, before retiring before the evening, after napping and prn for incontinence. R5's Minimum Data Set (MDS) dated ,d+[DATE] documents R5 is always incontinent of bowel and bladder. The facility policy enhanced barrier precautions dated 7/13/23 documents enhanced barrier precaution (EBP) should be used when contact precautions do not apply, open wounds that require a dressing change. The policy documents to ensure that disposable or washable isolation gowns and gloves are available to health care personnel (HCP), where high contact resident care activities may be required. The facility policy Hand hygiene dated updated 8/14/23 documents indications for handwashing- when hands are visibly soiled or contaminated with blood or body fluids, before and after eating and using the restroom. Handwashing can also be used routinely in the following clinical situations; after contact with body fluids, excretions, mucous membranes, non intact skin and wound dressings, before and after direct resident care, when moving from contaminated body site to clean site to clean body site during resident care, after removing gloves. The Facility's Medication Administration Policy, dated 11/18/17, documents 12. Appropriate hand washing is to be completed and/or alcohol based gel rub or (Advanced Hygiene Foam) must be used, throughout the medication pass. This should occur: Before and after medication pass, after touching an oral medication during administration, after touching any inanimate object possibly contaminated with microorganisms, handwashing between every resident is not required according to CDC guidelines. It is acceptable to use an antiseptic gel type solution between residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146011	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robings Manor Rhc	502 North Main Brighton, IL 62012

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 44967 Based on interview, and record review the facility failed to provide 80 square feet of floor space per resident in multiple resident bedrooms for 17 of 17 residents (R1, R2, R3, R4, R5, R6, R8, R13, R14, R15, R19, R21, R23, R26, R27, R29, R285) reviewed for room size in the sample of 29. Findings include: On 10/21/24 at 8:30 AM, V1, Administrator, provided a list of rooms that do not measure 80 square feet, these rooms are: 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 324, 325, 326, 327, 328, 329, 330, 331, 332 and 334. The residents living in these rooms are R1, R2, R3, R4, R5, R6, R8, R13, R14, R15, R19, R21, R23, R26, R27, R29, and R285. 10/24/24 at 8:45 AM, V1, Administrator, stated I know we have a lot of rooms that are less than the 80 square feet and we have a room waiver for those. V1 provided a list of Specific rooms for Room Size Waivers. 10/24/24 at 9:05 AM, V20, Regional Maintenance Director, stated I measured a couple of rooms, 101 and 325 and yes, they were less than the 80 square feet. I believe they were around 75 square feet. We do have a room waiver for this.