STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146031	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greek American Rehab Care Ctr	220 N First Street Wheeling, IL 60090

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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 0686 Level of Harm - 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** Based on observation, interview, and record review, the facility failed to ensure preventive measures were in place to prevent developing of new skin impairment and deterioration of current pressure ulcer, and failed to follow physician orders in wound management. These failures affect one (R144) residents in the sample of 31 reviewed for Pressure Ulcer/Wound Care Management, and resulted in R144 all developing a Stage 3 Sacral Pressure ulcer, with R144's wound needing debridement.Findings include:1.R144 was re-admitted on [DATE], with diagnoses listed in part but not limited to Alzheimer's disease, Dementia, History of falling, Pressure ulcer of sacral region stage 3.Active physician order sheet indicated: Bilateral heel suspension boots for offloading every shift. Low air loss mattress. Use one flat sheet only every shift. Moisture barrier for incontinence care as needed every shift for skin prophylaxis. (specialized) cushion when resident is up in chair to protect skin integrity. Sacrum- clean with normal saline solution, apply Medi honey, cover with island dressing every day shift and as needed for MASD (Moisture Associated Skin Damage). The order of Medi honey did not indicate if it is gel, paste, or cream. Braden scale for predicting pressure sore risk, dated 12/2/25, indicated at high risk.Comprehensive care plan, dated 1/13/26, indicated R144 has stage 3 pressure ulcer to sacrum. On 1/14/26 revised by V28, Care plan Coordinator, R144 has actual impairment to skin integrity related to fragile skin, incontinence, and impaired mobility. 1/13//25 noted with stage 3 pressure ulcer of the sacrum. See care plan for pressure ulcer. No care plan developed for prevention of skin impairment.R144's progress note, dated 12/31/25, indicated, upon assessment (R144) noted with MASD to the sacrum, wound measures1.5cm x 1.0cm x 0.1cm with small serous exudate. Cleansed with normal saline solution, applied Medi honey and covered with island gauze.R144's Wound care physician assessment note, dated 1/13/26, indicated: I have been asked to consult on this [AGE] year-old long term care who had MASD and today was found to have a stage 3 sacral pressure ulcer. Wound assessment indicated: Sacral is an acute stage 3 pressure injury ulcer acquired on 1/13/26 and has received a status of not healed. Initial encounter measurements are 0.7m x 0.6cm x 0.1cm. There is a small amount of serous drainage noted. Wound bed has 76-100% adherent yellow slough. Selective debridement with a total area debrided of 0.42sq cm was performed. Dermis and epidermis were removed along with devitalized tissue: biofilm and necrotic/eschar.On 1/13/26 at 11:00AM, V4, WCN (Wound Care Nurse), said R144 has an acquired stage 3 pressure ulcer on sacral area. On 1/14/26 at 9:58AM, V4, WCN, and V22, CNA (Certified Nurse Assistant), were preparing R144 for wound care. R144 was lying on an inflated mattress, not a low air loss mattress, as indicated in physician order sheet (POS). V4 said the mattress is a (specialized) mattress. The mattress is inflated, hard, and firm on the lower part, and soft, with an irregular indentation on upper part of the mattress. No bilateral heel suspension boots as indicated in POS. V22 repositioned R144 on his right side. V4 removed the dressing on sacral area. Observed minimal serous sanguineous drainage. V4 said R44 has a Stage 3 pressure ulcer with 25% yellow slough and 75% granulation tissue. V4 cleansed wound with normal saline solution (NSS) and apply Medi honey gel to sacrum and covered with bordered gauze dressing. On 1/14/26 at 11:00AM, review of R144's medical records showed the following: Physician order of low air loss mattress and bilateral heel boot were (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	not implemented as ordered.No skin care plan was developed for prevention of skin impairment. No care plan was developed when R144 was identified with MASD on 12/31/25. Care plan was not initiated until after the MASD deteriorated to a Stage 3 pressure ulcer.No weekly wound monitoring and documentation was done from 12/31/25 when MASD was identified.On 1/14/26 at 11:00 AM, V4 stated she only develops skin care plans and does weekly skin assessment/monitoring for stage 2 and above pressure ulcers. V4 added V28, Care plan coordinator, initiates the skin care plan if she missed it. V4 said she informed the IDT (Interdisciplinary Team) during morning meeting when R144 was identified with MASD. On 1/14/26 at 12:44PM, V28, Care plan Coordinator, said he was not aware R144 had MASD on 12/31/25. V28 said any changes in skin condition such as MASD on sacral area must be addressed in care plan to develop new interventions to enhance healing and prevent deterioration.Facility unable to provide policy on following physician order.Facility's policy on Skin condition monitoring reviewed 2/5/25 indicated:Policy: Nurse will complete comprehensive skin assessment on admission/re-admission, quarterly, annually or for significant change. A weekly skin condition check is completed by a nurse in conjunction with the resident's shower/bath schedule. All documentation related to the skin condition assessments and check will be documented.Procedure:1. Skin condition check will be done by the nurse assigned to the resident on shower day. At a minimum of once a week.2. Observe entire body for any broken areas, rashes, bruises, dry flaky skin, redness, irritation, wounds, etc. document findings in the skin progress notes.3.Wounds will be measured weekly by the wound care nurse or an outside provider such as a wound physician.4. Any new open wound areas, skin breaks or skin discoloration must be communicated to the resident/responsible party and physician by the assigned nurse.11. All resident with wounds and residents at high risk of a wound are reviewed and discussed in weekly NAR meeting. Facility's policy on Care plan reviewed 8/19/25 indicated:Procedure:The care plan will be formulated in terms of problems, goals, and interventions.MDS, CAA and comprehensive assessments will be reviewed to identify possible problems, goals and interventions.Significant change in condition/readmission: within 7 days of completion of the resident assessment, a care plan will be reviewed and updated by IDT.Care plan will be updated in the computer.When a new approach is added to the care plan, the day it is initiated will be placed at the beginning and electronically signed.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to follow management of waste bins. This deficiency has the potential to affect all 156 residents receiving food from the kitchen. Findings Include:On 1/13/2026 at 9:38 AM during kitchen initial round, one garbage bin with more than half full of refuse was without a lid/cover. Garbage bin was by food preparation area and there was no staff currently working in the vicinity of immediate area. V5 (Food Service Director) stated if there is no staff currently working in the area, garbage bins should have the lid on.On 1/13/2026 at 10:14 AM, V1 (Administrator) stated he is not sure of the policy for garbage bins management in the kitchen. V1 said he is not sure if garbage bin should have a lid when not in use.On 1/14/2026 at 9:35 AM, V2 (Director of Nursing) stated garbage bins should have a lid on when not in use for infection control purposes. Policy and ProcedureSubject: Kitchen Waste Bins - trash cans, Effective date 1/13/2026Policy: It is the policy of the Greek American Rehabilitation and Care Centre to maintain trash cans and waste receptacles in accordance with Illinois Department of Public Health (IDPH) guidelines to reduce the risk of infection, contamination, pests, and odors. All waste receptacles used in food service and healthcare areas shall be properly designed, maintained, and managed to promote sanitation and infection prevention.Purpose:To prevent the accumulation of unwanted pests, odors, and physical contaminants: Trash cans shall be used and maintained as follows:Trash cans shall be kept closed when not in active use.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to assure resident's personal privacy for electronic medical records and during administration of insulin. This deficiency affects two (R85 and R132) of three residents in the sample of 31 reviewed for Resident Privacy.Findings include: 1.On 1/13/26 at 11:41AM, V14, RN/Registered Nurse, administered an insulin injection to R85's abdominal area without providing privacy. The door was widely open visible to residents and employees passing through the hallway. V14 said she should have closed the door to provide privacy to R85 when administering insulin injection to her abdomen.2.On 1/13/26 at 10:19AM, observed a laptop on top of the treatment cart outside the door with the screen exposed, displaying R132's list of physician orders, visible to employees and residents walking past in the hallway. V4, Wound Care Nurse/WCN said she should have closed the computer screen to provide privacy for the confidential records of R132.On 1/13/26 at 2:20PM, V2, DON (Director of Nursing), said they should provide privacy when administrating insulin to abdominal area, and protect resident resident's confidentiality of medical records.Facility's policy on Resident's Rights for people in Long Term Care (LTC) facilities from Illinois LTC Ombudsman Program indicated: Your rights to privacy and confidentiality:You have a right to privacy and confidentiality of your personal and medical records. Your medical and personal care are private. Facility staff must respect your privacy when you are being examined or given care.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to refer a resident to the appropriate state-designated authority for a PASSAR (Pre-admission Screening and Resident Review) level 2 screening for evaluation and determination of newly evident serious mental illness related condition and prescribed medication, for one of one resident (R108) reviewed for a PASSAR level 2 screening in a sample of 31.Findings Include.On 1/15/2026 at 10:30am, R108's admission record documented a new Diagnosis, dated 5/12/2025, for Delusional Disorder, and on 12/20/2025 for Major Depressive Disorder, with added medication of Venlafaxine HCl 75 mg one time per day for Depression.On 1/15/2026 at 10:45am, V1 (Administrator) said, I know that residents with a mental illness should have a PASSAR level 2 completed but not if they have dementia. I have social services requesting a PASARR level 2 now for all the resident's that you've requested. On 1/15/2026 at 10:50am, V2(Director of Nursing-DON) said, (R108) should have a PASARR level 2 completed if he has a new psychiatric diagnosis and prescribed medication for any symptoms, I will make sure a PASARR level 2 is completed as soon as possible.R108's admission record, dated 1/15/2026, indicated R108 has a new diagnosis, dated on 5/12/2025, for Delusional Disorder ,and on 12/20/2025 for Major Depressive Disorder; a order summary report dated 1/15/2026 for Venlafaxine HCl Extended release 75mg one time per day; a PASRR level 1, dated 6/5/2024, with an outcome of no level 2 required at this time there is no evidence of intellectual developmental disability or a serious behavioral health condition. If changes occur or new information refutes these findings a new screen must be submitted. A care plan, dated 1/15/2026, with major depressive disorder. Per V2, the facility is unable to present a facility policy.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Preadmission Screening and Resident Review (PASARR, Level I and Level II) was conducted prior to admission affecting 2 of 3 residents (R12, R45) reviewed for PASARR in a total sample of 31.Findings Include:Findings include: 1.R12 is an [AGE] year-old female who was admitted into the facility with an initial admission date of 9/20/2021. R12 was diagnosed with a major depressive disorder on 10/15/2021. On 1/15/2026 at 11:00 AM, R12's physician order documented R12 is on Sertraline HCL Tablet 75 mg by mouth at bedtime. On 1/15/2026 at 11:00 AM, surveyor was not able to find PASARR level I screen for R12. On 1/15/2026 at 12:25 PM, V2 (Director of Nursing) said R12's PASARR Level I screen should have been completed. 2.Review of R45's records indicate an initial admission of 5/6/2021. Current diagnoses include schizoaffective disorder (9/23/2023), depressive type, other specified anxiety disorders (5/4/2025), major depressive disorder, single episode, unspecified (5/6/2021). Order Summary, 7/23/2025, read Divalproex Sodium Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium) for mood stabilizer Dx: Schizoaffective Disorder depressive type and Sertraline HCl Oral Tablet 100 MG (Sertraline HCl) for Schizoaffective Disorder, Anxiety Disorder. Care Plan report read, revision date 8/13/2025, Problem: PSYCHIATRIC ILLNESS R45 presents with a psychosis, schizophrenia. Her symptoms are manifested by depressed mood, excessive worry about health issues, excessive eating at times and extreme obsessive behavior. On 1/15/2026 at 9:25 AM, V1 (Administrator) and V2 (Director of Nursing) stated, There is no PASARR, Level I or Level II completed for (R45). PASARR Level I was requested and completed yesterday, 1/14/2026, with determination of Refer for Level II onsite. V2 stated PASARR should be completed for proper placement and appropriate services provided for residents. V2 stated the facility does not have policy for PASARR.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement care plan interventions and follow the recommendation of Occupational Therapy for residents with limited mobility. This affects two (R1 and R124) of three residents in the sample of 31 reviewed for Restorative Program.Findings include:1.R1 was re-admitted on [DATE] with diagnosis listed din part but not limited to Dementia, Type 2 Diabetes Mellitus, Osteoarthritis, Palliative care. Active physician order sheet indicated: reposition resident per turning schedule. Comprehensive care plan indicated she has ADL (Activity of daily living) self-care deficit. Intervention: Provide (specialized wheelchair) and assistance for mobility as needed. She has limited physical mobility due to weakness. Functional abilities and goals dated 12/29/25 indicated she is dependent with ADLs and transfers.On 1/13/26 at 10:57AM, R1 was sliding down in a high back chair in the dining room. R1 was confused, has facial grimacing, and appears uncomfortable. SV30, Activity Aide, who is monitoring the dining room, said she already observed R1 sliding but she cannot leave the dining room to ask the nursing staff to help her. She said she will wait until nursing staff comes to the dining room. V16, Registered Nurse/RN requested CNA to pull up and repositioned R1.On 1/13/26 at 11:56AM, R1 was sliding down again in a high back chair. V18, CNA, and V19, CNA, were standing in the dining room waiting for the lunch trays to come. Both CNAs observed R1 but did not help her. R1 had nonslip device for wheelchair underneath the wheelchair cushion. V19 said they usually applied another nonslip device on top of the wheelchair cushion to prevent her from sliding.On 1/13/26 at 12:42PM, V3, Restorative Nursing, said she was not aware R1 has issues with sliding down in her high back chair.On 1/14/26 at 12:34PM, V3, Restorative Nurse, was informed R1 has a care plan intervention for (specialized wheelchair) which helps with safe positioning/posture especially for resident who cannot sit comfortably or safely in a standard wheelchair. 2.R124 was re-admitted on [DATE], with diagnosis listed in part but not limited to hemiplegia and hemiparesis following cerebrovascular disease (CVA) affecting right dominant side, Aphasia, Dementia, stiffness of the right hand.Active physician order sheet indicated: Apply right resting hand splint to right wrist at night and off at am. Comprehensive care plan indicated he has an ADL self-care deficit related to hemiplegia. He is on right hand splint related to increase in right hand stiffness and recommended by Occupational Therapy (OT) due to history of CVA. Intervention: Perform AROM (active range of motion) to right hand before application of splint and after. R124's MAR (medication administration record) indicated application of right-hand splint at 8:00PM documented on MAR by nurses but no documentation of removal and providing of AROM before and after application as indicated in care plan.R124's Skilled therapy restorative program referral by Occupational therapist, dated 1/5/26, indicated: Brace/splints: Right half lap tray. (Right half lap tray is a wheelchair accessory that mounts on the right armrest to provide a support surface for the right arm. It is commonly used for positioning the arm. Extremity: right upper extremity. Wearing schedule: 4-5 hours/day. On 1/13/26 at 10:49AM, R124 was sitting in a wheelchair in front of the nursing station with a flexion contracture of right arm. V16, RN, was asked if R124 has splint for his right hand. V17 said it was discontinued when he was re-admitted .On 1/14/26 at 12:34PM, V3, Restorative Nurse, said she received the referral from OT for R124's restorative program. She said she did assess R124 but did not document. V3 said she incorporated the recommendation in the care plan. V3 was informed there are no updates in splint care plan and the last revision done was 12/20/23. No documentation was indicated in R124's medical records regarding OT's recommendations.On 1/15/26 at 10:01AM, V27, Restorative manager, said once they received recommendation from therapy for restorative program, they will screen the resident using restorative/functional assessment and care plan.On 1/15/26 at 10:49AM, V29, Therapy Director, said when a resident is discontinued for skilled therapy and will stay in the facility for long term care, they refer them to the Restorative nursing (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	program. The restorative nursing will do assessment/screen if the resident is appropriate to the restorative program and see if there are discrepancy between their assessment. They also provide training for CNAs and restorative aide the use of the devices if needed. Most of the time the restorative nurse accepted their recommendation. Facility's policy on Positioning revised 2/5/25 indicated: Policy:The facility will position residents in a comfortable and appropriate way.Facility's policy on ADL/Function Assessment reviewed 8/5/25 indicated: Policy: In an effort to ensure all our residents received the highest level of care possible with specific attention to physical function and reduce (wherever possible) the functional decline of our residents the following standards and measures have been established.Facility's policy on Referrals to Therapy effective 3/1/25 indicated:Purpose: This policy outlines the procedure for Long Term referrals for therapy servicesPolicy: 9. Upon discharge from therapy services, updated referral will be made to restorative nursing program with up-to-date functional status and program recommendations.Facility's policy on Referrals to Restorative Department effective 3/1/25 indicated: Purpose: This policy outlines the procedure for referrals for restorative nursing maintenance. Policy: 2. Once referral received, restorative nurse will screen patient to determine if resident is appropriate for recommended services.4. Appropriate task will be entered or discontinued from HER. Updated information will be communicated to designated staff.Facility's policy on Splint/Appliance reviewed 2/20/25 indicated: Purpose: To provide resident with therapeutic devices as needed to prevent worsening or to improve functioning.Policy: Residents who have contractures and require further evaluation will be assessed by the Occupational Therapist for a splint/ appliance. Responsibility: It is the responsibility of the nurses, CNAs, and restorative aide for splint application unless otherwise indicated. Procedure: 2. OT to develop splint and recommend splint schedule3. Splint and schedule will be addressed on care plan

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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 implement oxygen equipment storage affecting 1 of 2 (R118) residents reviewed for oxygen administration in a sample of 31. Findings Include:On 1/13/2026 at 11:04 AM, R118's oxygen nasal cannula tubing was on top of the bed, without a visible date, tubing touching the floor, and not currently in use. V21 (Certified Nursing Assistant) said she was not sure if tubing should be stored in a bag when not in use but stated would loop tubing and placed on top of the concentrator. V21 then looped the tubing and placed on top of oxygen concentrator. On 1/13/2026 at 11:24 AM, V10 (Registered Nurse) stated R118 uses her oxygen as needed and when not in used, tubing should be stored in a (plastic) bag for infection control purposes.On 1/14/2026 at 9:35 AM, V2 (Director of Nursing) stated when oxygen is not in used tubing should be stored in a clear plastic bag and tubing should not be touching the floor to prevent cross-contamination. Review of Care Plan Report, revision on 1/13/2026, read Problem: The resident has oxygen therapy r/t Shortness of breath. Order Summary Report, order date 7/27/2023, order status active, read Respiratory - Nasal Cannula prn 2L to maintain O2 Sats above 92%. Policy and ProcedureTitle: Oxygen Administration, reviewed 1/20/20251. Purpose: 1.1 To safely administer oxygen to treat and prevent the symptoms of hypoxia.2. Policy 2.3 Infection Control2.3.1 All oxygen tubing, humidifiers, masks, and cannulas used to deliver oxygen are single patient use only.When not in use tubing, masks, and cannulas should be bagged in a clear bag.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement its hospice services agreement in provision of information for coordinated hospice care. This deficiency affects one (R87) of three residents in the sample of 31 reviewed for Hospice Care Management.Findings include:On 1/13/26 at 10:49AM, V17, LPN (Licensed Practical Nurse), said R87 is on hospice care. R87 was up in a wheelchair in the dining room.R87 was re-admitted on [DATE], with diagnosis listed in part but not limited to Dementia, Palliative care, Parkinson's disease, Type 2 Diabetes Mellitus, Pressure Ulcer of sacral region stage 3. Active Physician order sheet (POS) indicated admit or eval to hospice (other hospice name) hospice 6/18/25. Active comprehensive care plan indicated R87 has a terminal diagnosis and is presently connected to (hospice name) for hospice care services. She has co-morbid complexities and maybe fatigues and have decreased social interaction with her peers. She is unable to make decisions about her care revised 1/7/26.On 1/14/26 at 10:30AM, R87's hospice binder was reviewed with V17, LPN, and V24, ADON (Assistant Director of Nursing). Hospice binder indicated (hospice name) hospice services of Illinois. No hospice plan of care in hospice binder. Both V17 and V24 said that Social Services coordinates with the hospice services with R87's hospice documents.On 1/14/26 at 11:06AM, V25, SSD (Social Service Director), and V26, SW (Social Worker), said they coordinated hospice residents' documents with hospice services chosen by resident/family. They obtain resident hospice information from the hospice services, and they make sure it's in resident's hospice binder such as hospice plan of care, nurses, and CNAs visit notes, and other pertinent records needed for coordinated care. Unable to find hospice plan of care. V25 said they will reach out to hospice to provide the documents.On 1/15/26 at 9:55AM, V26, SW, said they just requested R87's plan of care yesterday. R87's hospice plan of care indicated benefit period from 12/17/25 to 2/14/26.On 1/15/25 at 10:00AM, V2, Director of Nursing (DON), was informed R87's active POS indicated R87 is on (other hospice name) hospice care, but the care plan and hospice binder indicated (hospice name) hospice services. V2 said (other hospice name) hospice and (hospice name) services are different provider of hospice services. R87 is on (hospice name) hospice service. They should have physician order for the provider of hospice service to R87. They will update R87's POS. Facility's agreement between Hospice services provider dated 2/3/2020 indicated: Responsibilities of Hospice Care:(e) Provision of Information. Hospice shall promote open and frequent communication with facility and shall provide facility with sufficient information to ensure that the provision of facility services under this agreement is in accordance with the hospice patient's plan of care, assessment, treatment, planning, and care coordination. At minimum, hospice shall provide the following information to facility for each hospice patient residing at the facility:1. Plan of care, medications and orders. The most recent plan of care, medication information and physician orders specific to each hospice patient residing at facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146031	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greek American Rehab Care Ctr	220 N First Street Wheeling, IL 60090

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement appropriate infection prevention and control practices during medication administration. This deficiency affects all three (R49, R50 and R85) residents in the sample of 31 reviewed for Infection control prevention program.Findings include:1.On 1/13/26 at 9:31AM, V10, RN (Registered Nurse), took the portable Blood Pressure (BP) machine from the hallway without disinfecting it and brought to R50's room. V10 placed the BP cuff around R50's left wrist and checked the oxygen saturation on left finger. V10 obtained BP of 107/56mmHg, pulse rate of 69/minute and 90% oxygen saturation in room air. After obtaining her vital signs, she prepared her medications. She did not disinfect the medical equipment used. After she administered medication to R50, she is preparing to take vital signs of another resident without disinfecting the medical equipment.On 1/13/26 at 9:40AM, V10 said they usually disinfect medical equipment used for taking resident's vital signs before and after using it. V10 said she forgot to disinfect before and after each use.2.On 1/13/25 at 9:41AM, four students were wearing gloves and V13, Instructor, surrounding R49. As the surveyor entered the room, the instructor left the room, followed by her students in a hurry. The 3 students removed the gloves and performed hand hygiene by quickly rubbing hand sanitizer to their hands, but V12, student, removed her gloves and did not perform hand hygiene. V13, Instructor, said V12 should have performed hand hygiene after removing the gloves. V12, LPN (Licensed Practical Nurse) student, said she forgot to perform hand hygiene after removing the gloves. 3.On 1/13/26 at 11:32AM, V14, RN/Registered Nurse, performed blood sugar testing to R85 left little finger without using gloves. She obtained blood sugar of 209. She did not perform hand hygiene and proceeded to the medication cart located by the nursing station to prepare R85's sliding scale insulin. She did not disinfect the glucometer used. She prepared insulin Aspart 2 units from the vial without performing hand hygiene and without using gloves. At 11:41AM, V14, RN, prepared insulin medication to R85's left abdominal area without using gloves. She did not perform hand hygiene after insulin administration. V14 said she should have donned gloves when performing blood sugar testing, preparing insulin and administration of insulin to the resident. She said she should have performed hand hygiene before preparing medications and after administration of medication to resident. She said she should disinfect the glucometer after each resident use. Facility's policy on Hand Hygiene reviewed 1/8/26 indicated: Purpose: To promote effective hand hygiene practices, reduces the risk of healthcare-associated infections by preventing the spread of harmful germs. To ensure that staff, visitors and residents follow proper hand hygiene protocols to maintain clean environment. Policy: Examples of times/situations to perform hand hygiene are: *After contact with a patient's intact skin*After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient*After removing glovesProcedure Hand hygiene technique:Alcohol based hand rubAnti-microbial soap and waterFacility's policy on Cleaning and Disinfection reviewed 1/8/26 indicated: Purpose: To ensure the safety of our residents and staff by minimizing exposure to pathogensPolicy: it is the policy of the Greek American Rehabilitation and Care Centre to provide guidance on proper cleaning and disinfections techniques in accordance with applicable standards rules and regulations. Disinfection of common areas, medical equipment and devices. Guidelines for cleaning and disinfection: *All non-dedicated, non -disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies after use. Medical equipment disinfection: Using disinfectant wipes: hard surface disinfectants/disinfection wipes are used for routine decontamination of intermediate level of disinfection of semi critical items such as glucometers, thermometers, vital machines and other medical equipment