STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146052	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alhambra Rehab & Healthcare	417 East Main Street, Box 310 Alhambra, IL 62001

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45947 Based on interview and record review, the Facility failed to ensure residents were free from abuse for 2 of 4 residents (R23, R36) reviewed for abuse in the sample of 29. Findings include: 1-R23's Face Sheet documents R23 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, anxiety, major depressive disorder, and cognitive communication deficit. R23's Minimum Data Set (MDS) dated [DATE] documented R23 was severely cognitively impaired and ambulated via walker. R23's Care Plan printed 7/30/24 documents R23 has aggressive behaviors toward others. 2-R36's Face Sheet documents R36 was admitted to the facility on [DATE] with diagnoses including depression, hypertension, and cerebral infarction. R36's MDS dated [DATE] documented R36 was cognitively intact and independent with ambulation. R36's Care Plan printed 7/30/24 documents R36 has both verbally and physically aggressive behaviors. The Facility's Initial Report sent to the Illinois Department of Public Health (IDPH) on 5/7/24 documents, Administrator notified of incident between resident (R36) and (R23), with unwanted contact made between the two residents. Resident's {sic} immediately separated and assessed for injuries. PCP (Primary Care Physician) and POAs (Power of Attorneys) notified of incident. Investigation has begun with final investigation to follow. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R23's Incident Investigation by V2, Director of Nursing (DON), dated 5/7/24 documents, Resident entered into TV area and appeared to be speaking as she was entering. She sat down in the rocking chair and began rocking. (R23) on occasion was seen looking to other residents and sitting on the couch area and appeared to be speaking. Another resident stood up from the couch and walked over to (R23) and placed his hand on the back of the chair which stopped the rocking motion of the chair. He bent down to a face to face level and pointed his figer {sic} at her and appeared to verbalize something to her. The two continued to make verbalizing gesture to each other as (R23) stood up holding onto her walker. She began to back up as the other resident was in front of her. She raised her hand toward his face and he swiped his hand up to her hand and appeared to touch her arm in the process. (R23) back into a wheelchair behind her. Both residents continued to make verbal gestures as (R23) left the area. The nurse immediately intervened and assessed the situation. Both residents were separted {sic} for the rest of the evening. (R23) has a ST (Skin Tear) to Right forearm. On 8/1/24 at 2:45 PM, V2, DON, stated she watched the video of the altercation between R23 and R36. She stated R23 has behaviors and was antagonizing R36. R23 sat next to R36 on the couch, got in his face, and was pointing at him. R23 got up and moved, then paced around for a while and sat down in the rocker. R23 continued to say things and was looking directing at R36 and pointing at him. The video tape does not have sound, so she could not tell what R23 was saying, but R23 generally curses at whoever she comes across. After R23 sat down, R36 stood up and walked over to R23 and pointed at her. Then R23 stood up with the walker and tried to knock R36's hand away. V2 stated R36 has longer nails, so his hand might have caught her arm, but R23 also lost her balance and bumped into a wheelchair of a resident coming down the hall. V2 stated she was unable to tell from the video whether the skin tear came from R36's nails or the other resident's wheelchair. R23's Post-Incident Actions dated 5/7/24 documents, Narrative of incident: Resident engaged in a verbal confrontation {sic} with (R36). At that point (R23) started pointing her finger/hand in (R36)'s face. (R36) raised his hand/arm to protect himself causing (R23) to loose {sic} her balance and fall against someones wheel chair resulting in a skin tear to her right forearm. Immediate Post-Incident Action: Resident immediately separated {sic} and assessed for injuries. Kept one on one until behaviors ceased. Residents then monitored and kept distanced. R23's Incident Follow Up dated 5/7/24 documents, 24 Hour condition and injury appearance: St (Skin Tear) to rt (right) upper forearm. 8 steri strips with xeroform and dry dressing in place. All edges of ST approximated and without drainage. R23's 5/8/24 Progress Note by V14, LPN, documents (unknown) Certified Nursing Assistant (CNA) brought R23 to her with a large skin tear to right forearm, stating resident just had an altercation with another resident. The skin tear measured 7.5 cm (centimeters) and was treated with rolled gauze and tape to secure. V14 went to the tv area where the incident occurred. Resident R21 stated she was there and R23 was yelling at everyone and calling names, then R36 tried to diffuse the situation. R23 became more angry and put fingers in R36's face, then R36 grabbed her arm to protect himself. V14 then went to interview R36 who told her he did not grab R23's arm, but threw up his own arm to move her hand away, causing her to lose her balance and falling against someone's wheelchair. On 8/1/24 at 1:10 PM, attempted to contact V14, Licensed Practical Nurse (LPN), by phone and left voicemail requesting call back. As of 8/2/24 at 10:00 AM, no return call from V14, LPN, was received. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 9:37 AM R21 stated she could not recall the 5/7/24 incident between R23 and R36. On 7/31/24 at 9:10 AM, R23 was unable to provide any information regarding the 5/7/24 incident with R36. R36's Incident Investigation dated 5/7/24 documents, Resident was in tv area sitting on couch when another resident entered the area. The other resident was reported to have been having verbal aggressive behavior throughout the evening. (R36) walked over to the rocking chair where the other resident was sitting and placed his hand on the back of the chair which stopped the chair from rocking. He then bent over, looking the other resident in the face, and pointed his finger at her face. A motion of verbalization appeared to take place between the two residents. The other resident stood up from her chair and as the two continued to have gestures of verbalization, She began to back away and she reached up to his face. (R36) pushed her hand away and his hand appeared to touch her arm. This caused her to back into a wheelchair behind her. The residents continued to have verbalization between each other as she was leaving the area. (V2) had conversation with (R36) related to interactions between himself and other agitated residents. He agreed not to be aggressive toward {sic} other residents. On 8/1/24 at 2:20 PM, V6, Regional Minimum Data Set (MDS), stated she spoke with R36 who stated R23 was trying to move out of his way, but he did not hit her. On 8/1/24 at 9:47 AM, R36 stated R23 was sh*t talking on 5/7/24, but was unable to recall detailed information from the incident. On 8/1/24 at 9:39 AM V1, Administrator, stated that the injury to R23's arm did occur as a result to the altercation with R36. The Facility's Final Report sent to IDPH on 5/13/24 documents, (R36) was in TV area sitting on couch when another resident entered the area. (R23) was reported to have been loud verbally throughout the evening time and had entered the TV area where (R36) was located. (R36) walked over to where (R23) was sitting, pointing at her while she was sitting down. (R23) stood up as the two began to exchange words. She began to back away but reached her hand up to his face in a gesture. As (R36) tried to push away her hand, his hand did touch her arm, causing her to bump into wheelchair that was behind her. Residents were immediately separated and nurse notified of incident. Nurse assessed both residents. Evaluation of (R23) showed a scratch to her arm which needed in-house treatment of steri strips. No injury to (R36) noted. On 8/2/24 at 9:55 AM, V4, Regional Director of Clinical Operations, stated she expects the Facility to keep residents free from abuse. The Facility's Abuse Prevention Policy dated 8/16/19 documents, This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment.

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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 - 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** 34964 Based on observation, interview and record review, the facility failed to provide pressure ulcer treatment as ordered for 1 of 4 residents (R32) reviewed for pressure ulcers in the sample of 29. Findings include: On 8/1/24 at 1:05 PM V18, Licensed Practical Nurse (LPN) provided pressure ulcer treatment for R32, assisted by V20, Certified Nursing Assistant (CNA) for turning and positioning. They both washed their hands and donned gloves. V18 explained what she was going to do to R32 and (resident) stated, It's embarrassing. She reassured him it would not take too long and that his treatment needed to be done. V20 rolled R32 onto his right side and unfastened his adult diaper to expose his buttocks. R32 did not have a treatment on his stage 2 pressure ulcer in his gluteal cleft as ordered and he was incontinent of feces which was smeared over his exposed pressure ulcer. V18 stated the old dressing must have come off when they did R32's incontinent care around lunch time. V20 stated he had not provided care for R32 before this today and that he thinks one of the other CNAs would have changed him around lunch time. After V20 cleansed most of fecal material off R32's buttocks, V18 cleansed his pressure ulcer with wound cleanser, then applied a piece of calcium alginate above the pressure ulcer and secured it with a bordered dressing. She removed gloves and donned new gloves without performing hand hygiene. The pressure ulcer was still completely uncovered after V18 placed the treatment on R32's buttock. V18 then confirmed she was done with the dressing and removed her gloves. Writer informed her the pressure ulcer is not covered and V18 stated, yes it is,, and V20 confirmed that he could still see the pressure ulcer also as it was not covered with the dressing. V18 pulled the dressing off and attempted to put that same dressing over the pressure ulcer, but the edges became stuck together and she discarded it and got a new piece of calcium alginate and a new bordered foam dressing and applied them to the pressure ulcer. The calcium alginate was not completely covering the wound bed, but the bordered gauze did cover the ulcer. On 8/1/24 at 1:35 PM V21, CNA stated she had changed R32 before breakfast and around lunch time. She stated R32 did not have a treatment in place to his pressure ulcer on his coccyx either time that she provided incontinent care to him today. V21 stated she did not report to his nurse that he did not have a treatment in place. R32's Face Sheet documents his diagnoses include Adult Failure to Thrive, Malignant Neoplasm of Prostate, and Unspecified Dementia. R32's Minimum Data Set (MDS) dated [DATE] documents R32 is severely cognitively impaired, is occasionally incontinent of bladder and always incontinent of bowel and had on unhealed Stage 2 pressure ulcer at the time of this assessment. R32's Physician Order Summary Report dated 8/1/24 documents the order: 7/17/24: Clean wound with NS (normal saline) or WC (wound cleanser) cover with calcium alginate and border gauze once a day or prn (as needed) one time a day. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R32's Care Plan focus dated 7/17/24 documents: (R32) has pressure area to his sacral/coccyx area r/t (related to) weakness, end of life care. The goal for this care plan documents, (R32) will have no complications r/t pressure area of the sacral/coccyx area until the next review dated. Interventions for this care plan include: Administer medications as ordered. Monitor/document for side effects and effectiveness. Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Document location of wound, amount of drainage, peri-wound area, pain, edema, and circumference measurements (weekly). Encourage good nutrition and hydration in order to promote healthier skin. Evaluated wound for : size, depth, margins: peri wound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis. Notify physician as indicated. Float heels while in bed as tolerated. Monitor dressing when providing care to ensure it is intact and adhering. Report loose dressing to the nurse. Monitor pressure areas for changes in color, sensation, temperature and report any change to the nurse. Monitor/document/report to MD (Medical Doctor) prn for s/s (signs and symptoms) of infection: green drainage, foul odor, redness and swelling, red lines coming from the wound, excessive pain, fever. Pressure redistributing mattress on bed. R32's Skin and Wound Evaluation dated 7/17/24 documents he has an unstageable pressure ulcer with slough and/or eschar that was acquired in-house and first observed on 7/17/24 that measured length-1.7 centimeters (cm) by width-1.0 cm by depth-not applicable. It described wound bed as eschar 50 %. This assessment described the surrounding skin as fragile. Per this assessment, this is a new area and R32's Power of Attorney, MD and hospice were notified of new pressure ulcer. R32's Skin and Wound Evaluation dated 7/24/24 documents the pressure ulcer measurements as 1.4 cm by 0.8 cm with 50% granulation tissue and 50% slough. On 8/2/24 at 9:50 AM V4, Regional Director of Clinical Operations stated staff should ensure a treatment is done as ordered and make sure that treatment is in correct place when doing pressure ulcer treatment. She stated if a CNA is providing care for a resident and discovers a treatment fell off or becomes dislodged during care, that CNA should inform the nurse that the treatment is off so it can be replaced. The facility's policy, Treatments/Wound Care, revised October 2010 documents, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. 2. Wash and dry hands thoroughly. 3. Position resident. Place disposable cloth next to resident, (under the wound) to serve as a barrier to protect the bed linen and other body sites. 4. Put on exam glove. Loosen tape and remove dressing if applicable. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly or use hand sanitizer. 6. Put on gloves. Gown will only be necessary if soiling of your skin or clothing with blood, urine, feces, or other body fluids is likely. 10. Wear gloves when touching the wound or holding a moist surface over the wound. 11. Wash tissue around wound that is usually covered by the dressing, tape, or gauze with antiseptic or soap and water. Remove gloves, perform hand hygiene, and replace gloves. 12. Apply treatments as indicated.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34964 Based on observation, interview and record review the facility failed to provide complete incontinent care for 1 of 2 residents (R32) reviewed for incontinent care in the sample of 29. Findings include: On 8/1/24 at 1:05 PM V18, Licensed Practical Nurse (LPN) provided pressure ulcer treatment of R32, assisted by V20, Certified Nursing Assistant (CNA) for turning and positioning. They both washed their hands and donned gloves. V20 rolled R32 onto his right side and unfastened his adult diaper to expose his buttocks. V20 used disposable wipes and wiped feces from area of his pressure ulcer and around the pressure ulcer, and wiped most, but not all of the feces from his rectal area and buttocks. V20 then placed the soiled diaper with soiled wipes inside of it and some feces exposed on the outside of the diaper on the bed. After V18 finished pressure ulcer care, V20 applied a new adult diaper on R32 without washing the feces off his buttocks or cleansing his scrotum, penis or groin. R32's Face Sheet documents his diagnoses include Adult Failure to Thrive, Malignant Neoplasm of Prostate, Urinary Tract Infection (1/12/24) and Unspecified Dementia. R32's Minimum Data Set (MDS) dated [DATE] documents R32 is severely cognitively impaired, is occasionally incontinent of bladder and always incontinent of bowel and had on unhealed Stage 2 pressure ulcer at the time of this assessment. R32's Care Plan did not include a focused care plan regarding his incontinence or assistance he requires for Activities of Daily Living (ADLs). On 8/2/24 at 9:50 AM V4, Regional Director of Clinical Operations stated if staff are providing incontinent care to a resident who had been incontinent of bowel and bladder, that staff should ensure all areas touched by incontinence are thoroughly cleaned before putting on a new adult diaper. The facility's policy, Perineal Care, revised February 2018, documents, The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. For a male resident, b. Wash perineal area starting with urethra and working outward. K. Ask resident to turn on his side with his upper leg slightly bent, if able. Wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus and the buttocks.

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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. 45947 Based on interview and record review, the Facility failed to use the services of a Registered Nurse (RN) for at least eight hours daily. This has the potential to affect all 38 residents living in the Facility. Findings Include: The Facility's July 2024 RN (Registered Nurse) and LPN (Licensed Practical Nurse) schedule documents the Facility did not have a RN on 7/9/24, 7/19/24, 7/24/24, 7/27/24, or 7/28/24. The Facility provided time cards documenting V6, Registered Nurse (RN) and Minimum Data Set (MDS) Coordinator, worked on 7/9/24, 7/19/24, and 7/24/24, and V2, Director of Nursing (DON) worked on 7/27/24. The Facility was unable to provide documentation that a RN worked for at least eight hours on 7/28/24. On 7/31/24 at 7:52 AM, V2, Director of Nursing (DON), stated staffing has been an issue, and they have been trying to hire more nurses. On 8/1/24 at 10:10 AM, V13, Regional Director of Operations, stated the Facility does not have a policy regarding RN staffing, and they just follow the federal guidelines. The Facility's Long-Term Care Facility Application For Medicare and Medicaid dated 7/30/24 documents there are 38 residents living in the Facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45947 Based on observation, interview, and record review, the Facility failed to properly store and medications and discard expired medications. This has the potential to affect all 38 residents living in the Facility. Findings include: On 7/31/24 at 8:35 AM, the medication cart on A Hall was inspected with V3, Licensed Practical Nurse (LPN). The cart contained one opened bottle of over the counter liquid protein that was not dated upon opening and one opened bottle of over the counter cough syrup that was not dated upon opening. V3, LPN, stated the liquid protein had a label, but it must have worn off. She stated none of the residents use the cough syrup, so she will just throw it away. On 7/31/24 at 8:40 AM, the medication room on A Hall was inspected with V3, LPN. The refrigerator in the room contained one opened unlabeled multi dose Tubersol vial. V3, LPN, stated the vial should be dated upon opening, so she will get rid of it and order a new vial. She stated all residents receive Tubersol on admission and yearly. On 8/2/24 at 9:55 AM, V4, Regional Director of Clinical Operations, stated she expects the Facility to date medications upon opening and follow the medication storage policy. The Facility's Storage of Medications Policy revised April 2007 documents, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications must be stored separately from food and must be labeled accordingly. The Facility's Tubersol package documents the product should be discarded 30 days after opening. The Facility's Long-Term Care Facility Application For Medicare and Medicaid dated 7/30/24 documents there are 38 residents living in the Facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 42834 A. Based on Observation, Interview, and Record Review, the facility failed to establish and maintain a system of surveillance to identify communicable diseases or infection. This has the potential to affect all 38 residents in the facility. Findings include: On 8/1/2024 Facility Infection Control log documents on 7/21/2023 R196 Urinary Infection. No culture done. On 8/1/2024 Facility Infection Control log documents on 10/10/2023 R195 Urinary infection. No culture done. R195's Physician Order Sheets dated 10/2024 has no documentation of culture and sensitivity. R195's Physician Order Sheets dated 10/10/2023 documents Bactrim DS 800MG-160MG Tablet: Administer 1 tablet by mouth at 8am and 8pm everyday x 7 days related to UTI, Urinary Tract Infection. R195's medication administration record dated 10/2024 documents Bactrim DS 800mg-160MG Tablet. Administer 1 tablet by mouth at 8AM and 8PM. Everyday x 7 days related to UTI, Urinary Tract Infection. Order Date 10/10/2023. Start Date 10/10/2023. Stop Date 10/17/2023. Sulfamethoxazole/Trimethoprim. Administration dates document 10/10/2023 at 8PM. 10/11/2023-10/16/2023 at 8AM and 8PM. 10/17/2023 at 8AM. R196's Physician Order Sheets dated 7/2023 has no documentation of culture and sensitivity. R196's Physician Order Sheets dated 7/21/2023 Cephalexin 500MG Capsule: Administer 500mg oral at 8am, 12pm, 5pm every day. Stop date 7/28/2023. Generic: Cephalexin. R196's medication administration records dated 7/2023 document Cephalexin 500MG Capsule. Administer 500 MG oral at 8AM, 12PM, 5PM Everyday. Order date 7/21/2023. Start date 7/21/2023. Stop date 7/28/2023. Administration dates document 7/22/23-7/28/2023 8AM,12PM,5PM. Facility infection control log dated 6/9/2023-7/1/2024 contains no documentation of infection tracking for 7/2024. On 8/1/24 at 3:10 PM, V3, Infection Preventionist, IP, stated she just took over the role in October 2023. She tracks and trends facility infections with the floor plan, but has not yet started July 2024. She stated she had a floor plan for tracking organisms for previous months but it will take her a while to find them because her office has been moved and they are in boxes. On 8/2/2024 at 10:00AM V4, Regional Director of Clinical Operations, stated I would expect cultures to be completed prior to antibiotic administration. I would expect infection surveillance to be conducted throughout the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility policy date 2001 states Surveillance for Infections: The Infection preventionist will conduct ongoing surveillance for Healthcare Associated Infections and other epidemiologically significant infections that have substantial impact on potential resident outcome an that may require transmission based precautions and other preventative interventions. 34964 B. Based on observation, interview and record review, the facility failed to maintain Enhanced Barrier precautions and perform appropriate hand hygiene to prevent spread of infection for 1 of 6 residents (R32) reviewed for infection control in the sample of 29. Findings include: On 8/1/24 at 1:05 PM V18, Licensed Practical Nurse (LPN) provided pressure ulcer treatment of R32, assisted by V20, Certified Nursing Assistant (CNA) for turning and positioning. They both washed their hands and donned gloves. V20 rolled R32 onto his right side and unfastened his adult diaper to expose his buttocks. R32 did not have a treatment on his stage 2 pressure ulcer in his gluteal cleft as ordered and he was incontinent of feces which was smeared over his exposed pressure ulcer. V18 stated the old dressing must have come off when they did R32's incontinent care around lunch time. V20 used disposable wipes and wiped feces from area of his pressure ulcer and around the pressure ulcer, and wiped most of the feces from his rectal area and buttocks, but left some feces on both buttocks. V20 then placed the soiled diaper with soiled wipes inside of it and some feces exposed on the outside of the diaper on the bed. This soiled diaper was sitting right next to the area V18 was performing pressure ulcer care. After V20 cleansed most of fecal material off R32's buttocks, V18 cleansed his pressure ulcer with wound cleanser, then applied a piece of calcium alginate above the pressure ulcer and secured it with a bordered dressing. She removed gloves and donned new gloves without performing hand hygiene. V18 handed V20 a pair of gloves and told him to change your gloves, but he did not perform hand hygiene before donning the gloves. After V18 finished pressure ulcer care, V20 applied a new adult diaper on R32 without washing the feces off his buttocks or cleansing his scrotum, penis or groin. V18 and V19 did not wear appropriate Personal Protective Equipment (PPE) to maintain enhanced barrier precautions while providing pressure ulcer treatment and incontinent care. Neither wore a gown during care and neither hand sanitized when changing gloves during care. On 8/2/24 at 9:50 AM V4, Regional Director of Clinical Operations, stated if staff are providing incontinent care to a resident who had been incontinent of bowel and bladder, that staff should ensure all areas touched by incontinence are thoroughly cleaned before putting on a new adult diaper. V4 stated V18 and V20 should have worn a gown and gloves while performing wound care and incontinent care per the enhanced barrier precautions. V4 stated any time a staff changes gloves while providing care they should hand sanitize with alcohol gel or wash their hands with soap and water before donning new gloves. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146052	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alhambra Rehab & Healthcare	417 East Main Street, Box 310 Alhambra, IL 62001

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's policy, Enhanced Barrier Precautions Policy, revised 3/28/24 documents, Enhanced Barrier Precautions (EBP) expand the use of PPE and refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities. The use of gown and gloves for high-contact resident care activities is indicated for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC- targeted or other epidemiologically important MDRO when contact precautions do not otherwise apply. Wounds generally include chronic wounds, not shorter lasting wounds such as skin breaks or skin tears covered with an adhesive bandage or similar dressing. Examples of chronic wounds include, but are not limited to pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. The facility's policy, Handwashing/Hand Hygiene, revised August 2015, documents, This facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Wash hands with soap and water for the following situations: a. When hands are visibly soiled; and b. After contact with a resident with infectious diarrhea, including, but not limited to infections caused by norovirus, salmonella, shigella and C. difficile. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situations: g. before handling clean or soiled dressings, gauze pads etc; and m. after removing gloves.

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 45947 Based on interview and record review, the Facility failed to establish an infection prevention and control program that reduces the risk of adverse events, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use in 2 of 4 residents (R195, R196) reviewed for antibiotic stewardship in the sample of 29. Findings include: 1-The Facility's Infection Control Log lists No culture done for R195's 10/10/23 urinary infection. On 7/31/24 at 7:45 AM, requested culture and sensitivity for R195's 10/10/23 urinary infection from V4, Regional Director of Clinical Operations. On 8/2/24 at 10:00 AM, no culture and sensitivity was received. R195's October 2023 Physician Orders document an order for the antibiotic Bactrim DS 800 mg (milligram) - 160mg tablet with instructions to take one tablet twice daily for seven days for UTI (Urinary Tract Infection). R195's October 2023 Medication Administration Record (MAR) documents R195 received 14 doses of Bactrim DS. 2-The Facility's Infection Control Log lists No culture done for R196's 7/21/23 urinary infection. On 7/31/24 at 7:45 AM, requested culture and sensitivity for R196's 7/21/23 urinary infection from V4, Regional Director of Clinical Operations. On 8.2.24 at 10:00 AM, no culture and sensitivity were received. R196's July 2023 Physician Orders document an order for the antibiotic Cephalexin 500 mg capsule with instructions to take 500 mg three times daily. R195's July 2023 MAR documents R195 received 21 doses of Cephalexin. On 8/2/24 at 9:55 AM, V4, Regional Director of Clinical Operations, stated she expects the Facility to obtain urine cultures prior to starting antibiotics. The Facility's Antibiotic Stewardship Policy revised December 2016 documents, Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents. When a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued.