STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146177	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resthave Home-Whiteside County	408 Maple Avenue Morrison, IL 61270

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview and record review the facility failed to ensure tube feeding ordered by the physician was accurately measured. This applies to 1 of 2 residents (R4) reviewed for tube feeding in the sample of 17. The findings include:R4's current order summary shows, Resident has feeding tube and is NPO (nothing by mouth). The same report also shows, Jevity 1.5 cal (calorie)/fiber oral liquid (nutritional supplements), give 240 ml via [feeding tube] five times a day for nutrition support. On 1/28/26 at 11:21 AM, V4 Registered Nurse (RN) was giving R4 his scheduled tube feeding. She had an opened bottle of Jevity 1.5 calorie tube feeding formula dated 1/27/26 opened at 4:30 PM. She poured the tube feeding formula into a 30 ml (milliliter) medicine cup. A 30 ml medicine cup is marked at the top of the cup. She filled it up without making sure it was 30 mls. She continued to do that 4 times and poured each one into a 120 ml drinking cup. She stated, she does this 2 times because each time is a total of 120 mls equaling 240 mls total. The drinking cup was not full measuring 120 mls. She poured the first cup full of tube feeding formula into R4's feeding tube. Once that was complete, she used the 30 ml medicine cup to measure the tube feeding formula again. She did not make sure the amount was 30 mls and just poured the tube feeding formula into the medicine cup and then immediately into the other drinking cup. She was able to do that 2 times when the bottle of tube feeding formula was empty. She had to open another bottle of tube feeding formula to finish the tube feeding. She stated, that is how she always does his tube feedings. The 120 ml drinking cup was not full of tube feeding formula. On 1/28/26 at 4:37 PM, V2 Director of Nursing (DON) showed this surveyor a bottle of R4's tube feeding formula. Each bottle contains 1000 mls of formula. R4 is ordered to have 1,200 mls of tube feeding formula per day (240 mls X 5 = 1,200 mls). The formula bottle V4 RN used at 11:21 AM was opened and labeled that it was opened the day before prior to R4's 5:00 PM feeding. The 11:21 AM feeding, V4 RN did was R4's 5th feeding for that bottle. If R4 was given the correct amount of tube feeding formula V4 RN would have had to use 200 mls of the new bottle of formula instead she only used approximately 60 mls. The tube feeding was short 140 mls. V2 DON, confirmed this information and agreed that R4 was not given the correct amount of tube feeding formula that is ordered by the physician. She also stated, the nurses should be using the syringe that is provided to accurately measure the tube feeding formula ensuring R4 is receiving the correct amount ordered. R4's current care plan shows, R4 requires tube feeding (bolus feeds via [feeding tube] r/t esophageal dysphagia which as led to malnutrition. The facility's Enteral Nutritional Therapy, (tube feeding) policy dated 10/15/15 shows, Purpose: To provide liquid nourishment through a tube, inserted into the stomach. To provide hydration through a tube inserted into the stomach. Procedure: .5. Administer the amount of feeding to be given.

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

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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free from the use of unnecessary antibiotics for 4 of 5 residents (R6, R13-R15) reviewed for unnecessary medications in the sample of 17.The findings include: 1.R6's physician order dated 1/2/26 showed R6 was prescribed Macrobid (antibiotic) 100 mg (milligram), take one capsule once a day for treatment of a UTI (urinary tract infection). The order showed no stop date for the administration of the medication. On 1/28/26 at 2:35 PM, V2 Director of Nursing/Infection Preventionist (DON/IP) stated she shared the IP role with V1 Administrator, however V1 was not a nurse. V2 stated she was responsible for monitoring antibiotic surveillance in the facility and reviewing residents' antibiotic orders once a month. V2 stated all antibiotic medication orders should have an associated diagnosis for the medication, and a medication stop date. V2 stated the facility had some residents on antibiotics prophylactically for infections because they were admitted with the order or the resident or family just wants them to stay on the antibiotic. V2 stated she reviews all residents' prophylactic antibiotic orders once a month, with the facility's nurse practitioner (V18 NP), to ensure there is a need for and an associated diagnosis for the prescribed antibiotic. V2 stated R6 was started on Macrobid on 1/2/26 despite not having an acute UTI at the time, but because R6 has a history of having so many UTIs. V2 stated no repeat urinalysis was completed on R6 prior to her starting Macrobid on 1/2/26. V2 stated she had not reassessed R6 for the continued need for the medication since R6 started the medication on 1/2/26. 2.R13's physician order dated 12/30/25 showed R13 was prescribed Cephalexin (antibiotic) 250 mg, give one capsule in the morning for prophylaxis. The order showed no associated diagnosis for the order. The order showed no stop date. On 1/28/26 at 2:35 PM, V2 stated R13 was prescribed Cephalexin on 12/30/25 by his hospice service because of R13's history of UTI's, not because R13 had an acute UTI at the time. V2 stated the facility had never collected a urinalysis from R13 to assess and culture R13's urine prior to starting the Cephalexin. V2 stated she had never spoken with R13's hospice service about R13 being on the Cephalexin or his continued need for the medication. 3.R14's physician order dated 11/11/25 showed R14 was prescribed Bactrim (antibiotic) 400-80 mg, give half of a tablet once a day on Tuesday and Saturday for prophylaxis related to personal history of urinary tract infections. The order showed no stop date.On 1/28/26 at 2:35 PM, V2 stated R14 takes Bactrim because R14 apparently has had bad UTIs in the past and she wants to be on it. V2 stated R14 had never been diagnosed with an acute UTI while residing in the facility. The facility had never collected a urinalysis from R14 while she was in the facility. V2 stated she had never discussed R14's continued usage of Bactrim with V18 NP. 4.R15's admission record showed R15 was admitted to the facility on [DATE] and discharged on 1/9/26. R15's physician order dated 12/20/25 showed R15 was prescribed and received Nitrofurantoin (antibiotic) 50 mg, one capsule once a day for UTI prevention, from 12/21/25-1/9/26. On 1/28/26 at 2:35 PM, V2 stated R15 was admitted to the facility, from a local hospital, with a physician order for Nitrofurantoin. V2 stated, We just carried the order over from the hospital for his Nitrofurantoin because he had a history of UTI's. We never checked a urinalysis on (R15) prior to continuing the medication. I never spoke with (V18 NP) about the need to continue this medication. The facility's Policy and Procedure for Antibiotic Stewardship policy dated December 2022 showed, Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. The policy showed all antibiotic orders will include the drug name, dose, frequency of administration, start date, stop date, route of administration, and indications for use.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement and follow their Antibiotic Stewardship Program by not monitoring residents for inappropriate and unnecessary antibiotic use for 4 of 5 residents (R6, R13-R15) reviewed for antibiotic usage in the sample of 17. The findings include:The facility's Policy and Procedure for Antibiotic Stewardship policy dated December 2022 showed, Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. The purpose of the Antibiotic Stewardship Program is to monitor the use of antibiotics to our residents. Orientation, training and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics effects individual residents and the overall community. The policy showed all antibiotic orders will include the drug name, dose, frequency of administration, start date, stop date, route of administration, and indications for use.On 1/28/26 at 2:35 PM, V2 Director of Nursing/Infection Preventionist (DON/IP) stated she shared the IP role with V1 Administrator, however V1 was not a nurse. V2 stated, Antibiotic stewardship is something I am learning. I wasn't aware I was going to be the IP when I was hired as DON. Our ADON (Assistant Director of Nursing) was originally the IP, but she recently left abruptly. V2 stated she was responsible for monitoring antibiotic surveillance in the facility and reviewing residents' antibiotic orders once a month. V2 stated all antibiotic medication orders should have an associated diagnosis for the medication, and a medication stop date. V2 stated the facility had some residents on antibiotics prophylactically for infections because they were admitted with the order or the resident or family just wants them to stay on the antibiotic. V2 stated she reviews all residents' prophylactic antibiotic orders once a month, with the facility's nurse practitioner (V18 NP), to ensure there is a need for and an associated diagnosis for the prescribed antibiotic. 1.R6's physician order dated 1/2/26 showed R6 was prescribed Macrobid (antibiotic) 100 mg (milligram), take one capsule once a day for treatment of a UTI (urinary tract infection). The order showed no stop date for the administration of the medication. On 1/28/26 at 2:35 PM, V2 DON/IP stated R6 was started on Macrobid on 1/2/26 despite not having an acute UTI at the time, but because R6 has a history of having so many UTIs. V2 stated no repeat urinalysis was completed on R6 prior to her starting Macrobid on 1/2/26. V2 stated she had not reassessed R6 for the continued need for the medication since R6 started the medication on 1/2/26. 2.R13's physician order dated 12/30/25 showed R13 was prescribed Cephalexin (antibiotic) 250 mg, give one capsule in the morning for prophylaxis. The order showed no associated diagnosis for the order. The order showed no stop date. On 1/28/26 at 2:35 PM, V2 stated R13 was prescribed Cephalexin on 12/30/25 by his hospice service because of R13's history of UTI's, not because R13 had an acute UTI at the time. V2 stated the facility had never collected a urinalysis from R13 to assess and culture R13's urine prior to starting the Cephalexin. V2 stated she had never spoken with R13's hospice service about R13 being on the Cephalexin or his continued need for the medication. 3.R14's physician order dated 11/11/25 showed R14 was prescribed Bactrim (antibiotic) 400-80 mg, give half of a tablet once a day on Tuesday and Saturday for prophylaxis related to personal history of urinary tract infections. The order showed no stop date.On 1/28/26 at 2:35 PM, V2 stated R14 takes Bactrim because R14 apparently has had bad UTIs in the past and she wants to be on it. V2 stated R14 had never been diagnosed with an acute UTI while residing in the facility. The facility had never collected a urinalysis from R14 while she was in the facility. V2 stated she had never discussed R14's continued usage of Bactrim with V18 NP. 4.R15's admission record showed R15 was admitted to the facility on [DATE] and discharged on 1/9/26. R15's physician order dated 12/20/25 showed R15 was prescribed and received Nitrofurantoin (antibiotic) 50 mg, (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	one capsule once a day for UTI prevention, from 12/21/25-1/9/26. On 1/28/26 at 2:35 PM, V2 stated R15 was admitted to the facility, from a local hospital, with a physician order for Nitrofurantoin. V2 stated, We just carried the order over from the hospital for his Nitrofurantoin because he had a history of UTI's. We never checked a urinalysis on (R15) prior to continuing the medication. I never spoke with (V18 NP) about the need to continue this medication.