

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2026
NAME OF PROVIDER OR SUPPLIER Macomb Post Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8 Doctors Lane Macomb, IL 61455	
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 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, Interview and Record Review, the facility failed to ensure a resident with known bowel incontinence was provided dignified incontinence care for one of four residents (R1) reviewed for incontinence care assistance in the sample of seven. This failure resulted in R1 experiencing mental anguish and feeling embarrassed and ashamed of the lack of control of R1 bowels and the need for daily assistance with hygiene. Findings include: The facility's Dignity policy, dated 8/2019, documents Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. This same policy also documents Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: promptly responding to the resident's request for toileting assistance. The facility's Perineal/Incontinence Care policy, dated 9/11/2020, documents Purpose: To provide cleanliness and comfort to the resident, prevent infections and skin irritation, and observe the resident's skin conditions. The facility's Certified Nursing Assistant job description (undated), documents Job requirements: Be considerate, pleasant, and professional in the performance of his/her duties. Must have compassion, tolerance, and understanding for the residents of the facility. Main duties: Be sensitive to residents' families and respond in an appropriate professional way as the situation requires. Answer call lights promptly. Wash, clean, and dry all incontinent residents. Be responsible for well-being and nursing care of all residents assigned to his/her unit while on duty. R1's current Care Plan, dated 6/10/26, documents R1 was admitted to the facility on [DATE] and has diagnoses including Adult Failure to Thrive, Calculus of Gallbladder, Type two Diabetes Mellitus, and Generalized Anxiety Disorder. R1's Minimum Data Set assessment, dated 5/31/26, documents R1 has intact cognition, is continent of bladder function and is always incontinent of bowel function. This assessment also documents R1 requires substantial/maximal assistance with toileting and hygiene. R1's progress notes, dated 7/12/26 at 4:00 PM and completed by V20 (Registered Nurse), documents (R1) Refuses to get up and utilize toilet for bowel movements. Would rather be incontinent and have to have the CNA's (certified nursing assistants) clean him up after he has went in his (incontinence brief). Education given to resident that he has been cleared by therapy to get up into wheelchair and utilize toilet. On 7/23/26 at 2:15 PM, V15 (R1's family) stated R1 has been dealing with issues at the facility for awhile. V15 stated (R1) says they don't come change him and won't change him. (R1) cannot feel when he has to go to the bathroom. He told me that the CNAs (certified nursing assistants) are rough when cleaning him and that his testicle was bruised after cares and it was because the CNA squeezed and said she thought it was feces stuck on him. (R1) waits for hours just to get cleaned up so maybe there is stuck on feces. On 7/24/26 at 10:20 AM, R1 was sitting in his (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
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F 0677 Level of Harm - Actual harm Residents Affected - Few	room, in bed. R1 stated he has to wait a long time for his call light to be answered. R1 stated I have sat in a soiled diaper for an hour. They (facility staff) get mad at me about it. I can tell when I have to urinate, but I cannot tell when I have to go number two and then staff get mad at me for that. When (V18, CNA) was cleaning me up she grabbed my testicle and was too rough, she squeezed until I was bruised from it. I was upset because it hurt. (V18) and another CNA (unknown) laughed about it after it happened. R1 stated he feels at fault for being incontinent and feels like the staff make him wait a long time on purpose. R1 stated I don't want this to happen (bowel incontinence) and I feel embarrassed, like I am inconveniencing them. On 7/24/26 at 1:30 PM, V1 (Administrator in Training) and V17 (Regional Administrator) confirmed that R1 has been noted to be incontinent of bowel since admission and that his status has not changed. Both V1 and V17 confirmed they were not aware of staff making R1 feel ashamed or at fault for being incontinent and stated it is not acceptable for staff to treat residents in that manner. V17 stated the expectation is that Residents should receive prompt care when they are incontinent, and nurses and nursing assistants should never make residents feel embarrassed or at fault for being incontinent.		

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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. Based on observation, interview and record review, the Facility failed to provide scheduled menu items, palatable food, personal preference food temperature and personal preference portion sizes for dining services. This failure has the potential to affect all 58 Residents residing in the Facility. Findings include: The Facility Resident Room Roster, undated, documents 58 Residents residing in the Facility. The Facility Resident Nutrition Status Policy, dated 12/30/2024, documents: each Resident shall receive the correct diet, with preferences accommodated as feasible; food services and/or nursing personnel will assure that Residents are served the correct food; and prior to serving the food, the dietary aide/nurse aide must check the tray card to assure that the correct food is being served to the Resident. The Facility Food Service Director Job Description, undated, documents: responsible for planning, organizing, staffing, directing, coordinating, reporting, budgeting and physical management of the dietary department's employees and equipment in a way that the dietary services of the facility shall be maintained in accordance with established policies; establish, in conjunction with the dietary consultant, dietary policies and procedures and maintain their currency with new state and federal regulations; communicate pertinent information to the dietary employees; ensure the standardized recipes are being followed; inspect and supervise food preparation and service to ensure that infection control and the highest sanitation standards in all aspects of the dietary department are followed; assure proper maintenance of all food service equipment in all kitchen areas; visit with residents upon admission to make an initial nutritional assessment to ascertain food preferences; make rounds at meal times to check resident's acceptance of foods served; provide meal substitution for residents when requested; participate in Care Plan, Quality Assurance and Performance Improvement meetings; and implement plan of correction as required by State and Federal surveys. The Dietary [NAME] Job Description, undated, documents: purpose is to prepare, serve and maintain food safety with current federal, state and local standards, guidelines, regulations and established policies and procedures to assure that ongoing program of food safety and to assist with resident food preferences; prepare food in a safe and palatable manner that meets appearance, taste and quality expectations of residents; and maintain a clean and safe environment. V11's Employee Discipline Form, dated 7/20/26, documents: V11's position as the Facility Cook; a verbal warning for quality concerns and not following directions; detailed information including did not follow the menu or make necessary substitutions needed to follow the Registered Dietitians approved menu for residents and should have clarified appropriate substitutions. V11 was educated, retrained, in-services and change of positions from Dietary [NAME] to Dietary Aide. The Facility Grievance Log, dated 5/8/26 through 7/22/26, documents eight separate dietary issues (6/8/26, 6/9/26, 6/10/26, 6/15/26, 7/7/26, 7/14/26 and 7/22/26). The Facility Suggestion/Complaint/Grievance Communication Form, dated 6/8/26, documents R2's concerns no longer receiving menu prior to meals, no substitution options, meals are cold when received, feels like rights are being violated. The Facility Suggestion/Complaint/Grievance Communication Form, dated 6/9/26, documents R2's concerns, breakfast, lunch and dinner, no menu's and action taken for (6/8/26 and 6/9/26) we are going to start passing menu's out on Second Shift, in-servicing all Dietary staff on doing this also, in-servicing Dietary staff on substitutions and steam table is now fixed. The Facility Suggestion/Complaint/Grievance Communication Form, dated 6/10/26, documents, the food it is not good, the cook sent out salad for a hot meal and the food served cold and I feel you need a new (cook) that can cook. The corrective action taken was that new cooks are in the process of being trained and we are on a new menu cycle so you will be seeing different menu items. The (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility Suggestion/Complaint/Grievance Communication Form, dated 6/15/26, documents, the new kitchen staff, we have not filled out any menu for three weeks now. I have not had a complete hot meal for the same amount of time. Does anyone in the kitchen know how to turn the steam table on at all? It is also my understanding that the truck has not been here for the kitchen in over three weeks. The corrective action taken was we are going to start passing out menus again. Steam table is fixed. The truck has been here every week. The Facility Suggestion/Complaint/Grievance Communication Form, dated 7/8/26, documents, meals are cold, all of the time, actual meals do not match menus and portions are very small. The corrective action taken was that in-services will be conducted on portion control, food temperatures and right menus. The Facility Suggestion/Complaint/Grievance Communication Form, dated 7/8/26, documents that on 7/14/26, (R2) states that food is still cold, would like at least one meal a day to be warm. Portions continue to be small and that (R2) does not receive food as described on the menu. (R2) gave example of ordering a fried egg sandwich and only receiving an egg. R2 request that further changes be made to address concerns fully as there is a lot of room for improvement. The Facility Suggestion/Complaint/Grievance Communication Form, dated 7/22/26, documents that, (R8) stated during a care plan meeting that (R8) did not receive protein for a recent meal. The corrective action taken was, in-serviced all dietary staff on how to read diet tickets, how to do equal substitutions, cook did not follow menu or made the necessary substitutions that needed to follow the Registered Dietitian's approved menu. The [NAME] (V11) was demoted to dietary aide, wrote up, retained and in-serviced. On 7/23/26, a corrective action taken documents, In-serviced all dietary staff on accuracy and portion control and did audit on scoop sizes. Dietary staff are using the right scoops. V2 (Director of Nursing) sent order over to doctor for double portion sizes for (R2). On 7/23/26 at 12:54 pm, R2 (alert and oriented) stated, I have been complaining about the food for weeks. The food is rotten, and it is slop. The portion size is very small and it is normally just luke warm by the time I get it. Yesterday (7/22/26) I got one bite of chicken and was told that it was the right portion size. I keep telling them that I would like more food. If I ask for more or complain, they give me snarky remarks, and I can hear them talking about me. I am sick of cold meal and everything tasting terrible. On 7/23/26 at 1:10 pm, R4/Resident Council President (alert and oriented) stated, We get a lot of complaints about food in our council meetings. They do not follow the menus, and we do not get enough food. We tell them our issues, and they do not really seem to listen or do better. On 7/23/26 at 12:45 pm, R7 (alert and oriented) stated, The food is sometimes way too hard and cold. My potatoes were too hard today. The food temperature is way off, it is mostly cold. If we ask for more food, they do not give it to us. I recently had a room tray and instead of my meal, I literally got lettuce. One day, they forgot my supper, and the kitchen was closed, so the nurse was nice enough to get me a fast-food sandwich. On 7/23/26 at 11:21 am, V6 (R2's and R6's Sister) stated, I come to visit (R2) and (R6) every day. I gag every time I see their food. There is never enough either. When they had macaroni and, supposedly hamburger bake, he got literally six pieces of macaroni. I bring food in for my brother (R6) and (V19/R2's Spouse) brings in food for (R2). Neither one of them like the food and they do not get enough. We have had multiple discussions with them about this, but it does not seem to get better. On 7/23/26 at 12:56 pm, V19 (R2's Spouse) stated, I am here every single day, and I bring (R2) food, because the food is so bad and (R2) does not get enough. On 7/23/26 at 2:06 pm, V11 (former Dietary Cook/Dietary Aide) stated, I just got written up for not following the menus. I was the [NAME] and now I am a Dietary Aide. Sometimes we have to serve an alternative. Just this week, we forgot to put the turkey out of the freezer for turkey sandwiches, and we had to substitute the meat. I am not sure how it gets told to the Residents when we must substitute. There have been occasions where we cannot find a meal ticket, they get lost, I think the CNA's accidentally (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	leave them in the Resident rooms.On 7/24/26 at1:50 pm, V4 (Dietary Manager) stated, We have all new staff. (V11) was our former cook and I had to demote (V11) because (V11) was not following the menus and substituting recipes.On 7/24/26 at 2:00 pm, V1 (Administrator) stated, We are trying to make a lot of changes in the Dietary Department. We also try and address each individual dietary complaint as they happen.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the Facility failed to maintain clean kitchen floors, clean walk-in cooler, clean walk-in refrigerator units/coolers, clean inside/front/handles of the refrigerators and label/date opened food items in the refrigerator. This failure has the potential to affect all 58 residents residing in the Facility. Findings include: The Facility Resident Room Roster, undated, documents 58 Residents residing in the Facility. The Facility Food Service Director Job Description, undated, documents: responsible for planning, organizing, staffing, directing, coordinating, reporting, budgeting and physical management of the dietary department's employees and equipment in a way that the dietary services of the facility shall be maintained in accordance with established policies; establish, in conjunction with the dietary consultant, dietary policies and procedures and maintain their currency with new state and federal regulations; and inspect and supervise food preparation and service to ensure that infection control and the highest sanitation standards in all aspects of the dietary department are followed. The Dietary [NAME] Job Description, undated, documents: purpose is to prepare, serve and maintain food safety with current federal, state and local standards, guidelines, regulations and established policies and procedures to ensure that ongoing program of food safety; prepare food in a safe and palatable; and maintain a clean and safe environment. The Facility Grievance Log, dated 5/8/26 through 7/22/26, documents eight separate dietary issues (6/8/26, 6/9/26, 6/10/26, 6/15/26, 7/7/26, 7/14/26 and 7/22/26). On 7/23/26 at 10:10 am, the walk-in refrigerator and walk-in freezer door handles had a substantial amount of thick sticky substance with debris in the crevices of the handles, and the floors had a moderate amount of debris. The surface of the floors of the walk-in refrigerator, walk-in freezer and kitchen exhibited a heavy tactile resistance, causing the soles of the surveyor's shoes to stick and adhere to the floor. On 7/23/26 at 10:10 am, the stand-up food preparation refrigerator, located in the food preparation area, had a substantial amount of thick sticky substance with debris on the handles. The stand-up food preparation refrigerator had the following food items: open undated bottle of 16-ounce soda, with no name; a container of gravy, dated 7/13/26; coleslaw dated 7/17/26; no date, partially uncovered nine individual serving bowls of whipped fruit salad; and an open container of half-n-half dated 7/15/26. On 7/25/26 at 8:31 am, the walk-in refrigerator, walk-in freezer door handles and the stand-up food preparation refrigerator had a substantial amount of thick sticky substance with debris in the crevices of the handles. On 7/25/26 at 8:31 am, the stand-up food preparation refrigerator had two open undated bottles of 16-ounce soda, with no name and French salad dressing container, dated 2/8/26 and 6/9/26. On 7/23/26 at 10:10 am, V4 (Dietary Manager) stated, We usually mop the floors once a month. We just swept the floors but did not mop them. We clean the outside of the refrigerators and freezer handles about every week. V4 verified the sticky door handles with debris and the sticky floors. On 7/24/26 at 2:00 pm, V1 (Administrator) stated, We are trying to make a lot of changes in the Dietary Department. We also try and address each individual dietary complaint as they happen. I went into the kitchen, and I even noticed the floors really were sticky, so I had them clean the floors. We may need to look at the cleaning schedule and make sure it is being followed.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review the Facility failed to respond to Resident call lights in a timely manner and comply with Resident requests for assistance, for five of seven Residents (R1, R2, R4, R6 and R7) reviewed for call light response in a sample of sevenFindings include:The Facility Resident Call Bells Policy, dated 11/5/25, documents: will be adequately equipped to allow Residents to call for staff assistance through a communication system which relays the call directly to a staff member or centralized staff work area from each Resident's bedside, toilet and bathing facilities; calls for assistance shall be answered timely; and any staff member that hears or sees an alert from a Resident from the communication system is responsible to answer within reasonable timeframe; non-clinical staff are to answer requests for assistance from the communication system.The Facility Concern/Grievance Form, dated 4/1/26, documents lights not answered in a timely manner and action taken was call light audits, showing longest call light on for three minutes.The Facility Resident Council Minutes, dated 5/5/26, document follow-up concerns with lights not being answered.The Facility Resident Council Minutes, dated 6/16/26, document Residents concerned about timely response to call lights.The Facility Concern/Grievance Form, dated 6/16/26, document Residents would like better customer service from Certified Nursing Assistants (CNA) and would like call lights to be answered in a timely manner and call light audits and CNA education reviewed, and action taken.The Facility Resident Council Minutes, dated 7/16/26, document Residents are concerned about their call lights not being answered in a timely manner on Second and Third Shift.On 7/24/26 at 10:01 am, R1 (alert and oriented) stated, My call light takes forever to get answered.On 7/23/26 at 12:54 pm, R2 (alert and oriented) stated, Call lights take a very long time, all the time, usually over an hour to get answered.On 7/23/26 at 1:10 pm, R4/Resident Council President (alert and oriented) stated, My call lights take about anywhere from a half-an-hour to an hour to get answered. I heard a lot of call light complaints in Resident Council meetings. We have been trying to work on that issue for quite some time.On 7/23/26 at 1:32 pm, R6 (alert and oriented) stated, We have issues with call lights, they take forever, usually way too long.On 7/23/26 at 12:45 pm, R7 (alert and oriented) stated, Oh yea, the call lights getting answered is random, always takes a long time. I am constantly having issues with them.On 7/23/26 at 11:21 am, V6 (R2's and R6's Sister) stated, I come to visit (R2) and (R6) every day. I am their sister. I have sat in their rooms and had the call light on for over an hour and no one check on them (R2 or R6). It just makes me worry for the people that do not have family, if they are taking that long when I am here, it makes me worry how long it is taking them to help the ones that do not have any family.On 7/23/26 at 12:56 pm, V19 (R2's Spouse) stated, I am here every single day, and they really do take a long time to answer the call lights, I am just glad that I am here to help (R2). Half the time, (R2) is lucky that they even have time to give (R2) water, sometimes (R2) goes without water. I just filled up the water pitcher because they still had not been in here yet.On 7/23/26 at 1:48 pm, V7 (Ombudsman) stated, I have been working on the call light issues at that Facility.On 7/24/26 at 2:00 pm, V1 (Administrator) stated, We have been doing call light audits. We know that we have an issue with the call lights, so we in-serviced the CNA's.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, Interview and Record Review, the facility failed to ensure allegations of resident abuse and neglect were reported to the facility's abuse coordinator and the state agency for three of seven residents (R1, R3, R5) reviewed for Abuse in the sample of seven. Findings include: The facility's Residents Right to Freedom from Abuse, Neglect, and Exploitation policy, dated 2026, documents The facility's residents have the right to be free from abuse, neglect, misappropriation of their property, and exploitation as defined in this policy. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This policy also documents In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility shall: Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported in the proper time frame pursuant to this policy. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with state law, including to the state agency within five working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. On 7/23/26 at 11:40 AM, V1 (Administrator in Training) stated she does not have any reported abuse allegations since starting as the Administrator. V1 stated she began her role on 3/9/26. 1. R1's current Care Plan, dated 6/10/26, documents R1 was admitted to the facility on [DATE] and has diagnoses including Adult Failure to Thrive, Type two Diabetes Mellitus, and Generalized Anxiety Disorder. On 7/23/26 at 2:15 PM, V15 (R1's family) stated R1 has been dealing with issues at the facility for awhile. V15 stated (R1) says they don't come change him and won't change him. (R1) cannot feel when he has to go to the bathroom. He told me that the CNAs (certified nursing assistants) are rough when cleaning him and that his testicle was bruised after cares and it was because the CNA squeezed and said she thought it was feces stuck on him. (R1) waits for hours just to get cleaned up so maybe there is stuck on feces. On 7/24/26 at 10:20 AM, R1 was sitting in his room, in bed. R1 stated When (V18, CNA) was cleaning me up she grabbed my testicle and was too rough, she squeezed until I was bruised from it. I was upset because it hurt. (V18) and another CNA (unknown) laughed about it after it happened. R1 stated the nurses had the physician (V13, facility Physician Assistant) exam R1's genitals and V13 confirmed the presence of the bruise. R1 denied ever talking to V1 (Administrator in Training, AIT) about the incident and confirmed that V18 has continued to provide care for him since the incident. R1's Progress Note, dated 7/14/26 at 8:00 AM, documents R1 was seen by V13 and examined for a bruise to R1's testicle and acute onset of pain after cares were provided by facility staff. 2. R3's current Care Plan, dated 5/1/26, documents R3 was admitted to the facility on [DATE] and has diagnoses including Generalized Anxiety and Morbid Obesity. R3's Minimum Data Set assessment, dated 5/26/26, documents R3 has intact cognition. R3's Suggestion/ Complaint/ Grievance Communication Form, dated 5/11/26, documents (R3's) verbal form with assistance of Administrator (V1, Administrator in Training). CNA (certified nursing assistant) needs to be more gentle with peri care. This form documents (R3) doesn't want CNA to care for her anymore. On 7/23/26 at 1:40 PM, R3 was sitting in her room in a recliner chair at her bedside. R3 confirmed that in May she had an incident with a CNA (V14, certified nursing assistant) that upset her very much. R3 stated (V14) was cleaning me up and hurt me. She was way too rough and entered places she shouldn't. (V14) did it three times and I told her after the first time that it hurt (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	me. She just said, well I have to clean there and kept doing it. I was married for many years, and my husband didn't put his fingers there. There was another CNA (unknown) who heard me complaining and she must've told the administration. (V1) came and talked to me and the CNA no longer cares for me. I've seen her but she doesn't provide care for me. I can talk and report things like this, even though it's embarrassing and I didn't really want to, but I think about the residents who can't talk for themselves or speak up.3. R5's current Care Plan, dated 6/5/26, documents R5 was admitted to the facility on [DATE] and has diagnoses including Anxiety, Dementia, Hemiplegia, Hemiparesis and Major Depressive Disorder.R5's Suggestion/ Complaint/ Grievance Communication Form, dated 6/3/26, documents V16 (R5's family) completed the form on 6/3/26. V16 wrote I feel that my mother (R5) is not getting the proper care. She does not get a bath every week and it takes CNAs forever to change her. I also feel that (R5) has more bruises than she should. She does not eat well at meals, and no progress has been made. This form continues to include V16's concerns that R5 experiences long call light wait times and has back pain and cannot stand on her own, making her at the mercy of whoever can help her.On 7/24/26 at 11:24 AM, V1 (AIT) confirmed she is the facility's abuse coordinator and stated Any willful abuse should be reported to me. V1 verified that she was not made aware of R1 having bruising to his genital area and she would have expected that to be reported to her. V1 stated for R3's grievance, she reached out to her corporate team and was told it was a customer service concern and did not have to be reported as abuse. V1 stated she did not report the allegation to the state agency. V1 also stated she was made aware of the concerns for R5, after V16 (R5's family) filled out a complaint/grievance form and stated she did not report the allegations included in the complaint to the state agency.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2026
NAME OF PROVIDER OR SUPPLIER Macomb Post Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8 Doctors Lane Macomb, IL 61455	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, Interview and Record Review, the facility failed to ensure allegations of resident abuse and neglect were investigated and residents were immediately protected to prevent further potential abuse for three of seven residents (R1, R3, R5) reviewed for Abuse in the sample of seven. Findings include: The facility's Residents Right to Freedom from Abuse, Neglect, and Exploitation policy, dated 2026, documents The facility's residents have the right to be free from abuse, neglect, misappropriation of their property, and exploitation as defined in this policy. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This policy also documents The facility explicitly and expressly prohibits, and will take steps to prevent, any associates from engaging in any behaviors or actions that may result in the abuse, neglect, and exploitation of residents and misappropriation of resident property. The facility will investigate any allegations made alleging abuse, neglect, and exploitation of residents and misappropriation of resident property. The facility will ensure that any suspicion of resident abuse, neglect, misappropriation of property, and exploitation is coordinated with the facility's QAPI (Quality Assurance and Performance Improvement) program. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility shall: Have evidence that all alleged violation are thoroughly investigated. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with state law, including to the state agency within five working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. On 7/23/26 at 11:40 AM, V1 (Administrator in Training) stated she does not have any abuse allegations or investigations since starting as the Administrator. V1 stated she began her role on 3/9/26.1. R1's current Care Plan, dated 6/10/26, documents R1 was admitted to the facility on [DATE] and has diagnoses including Adult Failure to Thrive, Type two Diabetes Mellitus, and Generalized Anxiety Disorder. On 7/23/26 at 2:15 PM, V15 (R1's family) stated R1 has been dealing with issues at the facility for awhile. V15 stated (R1) says they don't come change him and won't change him. (R1) cannot feel when he has to go to the bathroom. He told me that the CNAs (certified nursing assistants) are rough when cleaning him and that his testicle was bruised after cares and it was because the CNA squeezed and said she thought it was feces stuck on him. (R1) waits for hours just to get cleaned up so maybe there is stuck on feces. On 7/24/26 at 10:20 AM, R1 was sitting in his room, in bed. R1 stated When (V18, CNA) was cleaning me up she grabbed my testicle and was too rough, she squeezed until I was bruised from it. I was upset because it hurt. (V18) and another CNA (unknown) laughed about it after it happened. R1 stated the nurses had the physician (V13, facility Physician Assistant) exam R1's genitals and V13 confirmed the presence of the bruise. R1 denied ever talking to V2 (Director of Nursing) or V1 (Administrator in Training, AIT) about the incident and confirmed that V18 has continued to provide care for him since the incident. R1's Progress Note, dated 7/14/26 at 8:00 AM, documents R1 was seen by V13 and examined for a bruise to R1's testicle and acute onset of pain after cares were provided by facility staff. R1's electronic medical record does not document any detailed notes, skin assessments, incident narrative or investigation related to R1's bruising and pain to his genitals. On 7/24/26 at 10:45 AM, V2 (Director of Nursing) stated (R1) was seen by (V13, Physician Assistant) for the bruising to his scrotum. V2 stated this visit was because R1 complained that his testicles hurt. V2 denied having any further records, interviews or evaluation to determine the cause and details around (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2026
NAME OF PROVIDER OR SUPPLIER Macomb Post Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8 Doctors Lane Macomb, IL 61455	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's injury.2. R3's current Care Plan, dated 5/1/26, documents R3 was admitted to the facility on [DATE] and has diagnoses including Generalized Anxiety and Morbid Obesity.R3's Minimum Data Set assessment, dated 5/26/26, documents R3 has intact cognition.R3's Suggestion/ Complaint/ Grievance Communication Form, dated 5/11/26, documents (R3's) verbal form with assistance of Administrator (V1, Administrator in Training). CNA (certified nursing assistant) needs to be more gentle with peri care. This form documents (R3) doesn't want CNA to care for her anymore.On 7/23/26 at 1:40 PM, R3 was sitting in her room in a recliner chair at her bedside. R3 confirmed that in May she had an incident with a CNA (V14, certified nursing assistant) that upset her very much. R3 stated (V14) was cleaning me up and hurt me. She was way too rough and entered places she shouldn't. (V14) did it three times and I told her after the first time that it hurt me. She just said, well I have to clean there and kept doing it. I was married for many years, and my husband didn't put his fingers there. There was another CNA (unknown) who heard me complaining and she must've told the administration. (V1) came and talked to me and the CNA no longer cares for me. I've seen her but she doesn't provide care for me. I can talk and report things like this, even though it's embarrassing and I didn't really want to, but I think about the residents who can't talk for themselves or speak up.R3's electronic medical record does not document any investigation, interventions or incident details related to R3's grievance completed in May 2026.The facility's Interdisciplinary note, provided by V1 on 7/24/26 at 1:15 PM, documents a written statement was obtained from V14 on 5/11/26 that documents V14 assisted R3 with toilet hygiene on 5/6/26. V1 confirmed this is the only written staff interview or statement that she has and stated it is not a part of R3's medical record. V1 also confirmed she is unsure if V14 was suspended from working pending investigation.3. R5's current Care Plan, dated 6/5/26, documents R5 was admitted to the facility on [DATE] and has diagnoses including Anxiety, Dementia, Hemiplegia, Hemiparesis and Major Depressive Disorder.R5's Nursing Progress notes, dated 5/23/26 at 9:47 AM, documents (R5) has a bruise to the right side of her forehead that is very light in color. (R5) states that she does not know what happened. She denies pain. ADON (V8, former Assistant Director of Nursing) notified and looked at area. (V16, R5's family) aware.R5's Suggestion/ Complaint/ Grievance Communication Form, dated 6/3/26, documents V16 (R5's family) completed the form on 6/3/26. V16 wrote I feel that my mother (R5) is not getting the proper care. She does not get a bath every week and it takes CNAs forever to change her. I also feel that (R5) has more bruises than she should. She does not eat well at meals and no progress has been made. This form continues to include V16's concerns that R5 experiences long call light wait times and has back pain and cannot stand on her own, making her at the mercy of whoever can help her.On 7/24/26 at 11:24 AM, V1 (AIT) confirmed she is the facility's abuse coordinator and stated Any willful abuse should be reported to me. V1 denied having an investigation or statements from R1's incident and verified that she was not made aware of R1 having bruising to his genital area but confirmed that V2 (Director of Nursing) was aware. V1 stated for R3's grievance she does not have an abuse investigation, interviews with other residents or written statements from staff members, aside from the CNA (V14) involved. V1 stated the CNA (V14) can no longer care for R3 since the incident. V1 stated she was only made aware of the concerns for R5, after V16 (R5's family) filled out a complaint/grievance form and verified she did not record any statements or conduct interviews with other residents and staff or complete an investigation after learning of V16's allegations. V1 confirmed that there are no notes in R5's record that document the detailed allegations, cause or any investigation to address the concerns.		