STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145266	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fondulac Rehabilitation & Hcc	901 Illini Drive East Peoria, IL 61611

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 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** 38396 Based on interview and record review, the facility failed to report an allegation of staff to resident mental abuse to the state agency for one of three residents (R23) reviewed for abuse in the sample of 47. Findings include: The facility's Abuse Prevention Program policy, dated 11/28/16, documents The facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. 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 facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our residents. This policy also documents Initial Reporting of Allegations. The facility must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, misappropriation or resident property, and reasonable suspicion of a crime, are reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures. If the events that cause the reasonable suspicion result in serious bodily injury or suspected criminal sexual abuse, the report shall be made to at least one law enforcement agency or jurisdiction and (the state agency) immediately after forming the suspicion (but no later than two hours after forming the suspicion), otherwise the report must be made not later than 24 hours after forming the suspicion. R23's Cognitive assessment dated [DATE] documents R23 is cognitively intact. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/18/24 at 11:37 AM, R23 stated I was a resident at the facility until last Friday when I moved to my own apartment. The nurse (V8, Licensed Practical Nurse) works day shift is not liked by several residents. (V8) would always hold my medications and then laugh about it. (V8) would give me a hard time, mostly with medications and then laugh when I would get upset. She would laugh about how long it would take her and I take a lot of medications. She would make me the last person but for sure if I came up and asked for my medications then she would make me wait even longer on purpose and give me mine last. I spoke to the administrator (V1, Administrator in Training) about this, and I talked mostly to the Director of Nursing (V2) and Assistant Director of Nursing. I saw them go and talk to (V8) and then they both acted funny towards me afterwards. I don't know what she told them, but they believed her over me. This happened on 8/6/24 that I told (V3) all of this. On 8/19/24 at 11:00 AM, V1 (Administrator in Training) stated I do not have any abuse allegations or investigations since I have been here. I don't see where the prior there was any for the last year. But I have been here since June, and I don't have anything for Abuse. 08/19/24 1:53 PM, V10 (Certified Nursing Assistant, CNA) stated she was working on the day (R23) was very upset about (V8) being his nurse. V10 stated (R23) is normally a cool and calm resident with little complaint. That day however, he was very upset, angry and emotional. He said she (V8) is evil and had been verbally abusive. The ADON (V3) was aware. She was the one who gave him his medications that day and she was down there talking to him about the situation. On 8/19/24 at 2:02 PM, V3 (Assistant Director of Nursing) confirmed she talked to R23 at some point over the last three weeks about V8. V3 stated (R23) told me (V8) would not do his insulin and blood glucose checks the way he felt they should be done. There was a personality conflict there. He would call me on the facility phone and ask me to give his medications. (R23) refused to take them from (V8) because he said he didn't trust her. When he brought this to our attention, we talked with him and with (V8) and I stopped putting her on that hall until (R23) was out of the building. (R23) would tell me I am not going to take my medications from (V8), I don't trust her. (V1, Administrator in Training) is the Abuse coordinator. He did the investigation with us (V2 Director of Nursing and V3), and we determined that we would avoid conflict and keep her off of (R23's) hall until he discharged . On 8/19/24 at 2:11 PM, V1 confirmed he did not submit an Abuse report to the state agency when he was informed that R23 had conflicts with V8. V1 stated (R23) stated he didn't like (V8). He said when she works his hall, he didn't like her and (R23) didn't want (V8) to give him his medications. He did not like her personality. I didn't see that as abuse.

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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 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** 38396 Based on interview and record the facility failed to immediately remove an employee accused of mental abuse from resident care and complete an abuse investigation for alleged staff to resident abuse for one of three residents (R23) reviewed for Abuse in the sample of 47. Findings include: The facility's Abuse Prevention Program policy, dated 11/28/16, documents The facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. 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 facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our residents. This policy also documents Employees of this facility who have been accused of mistreatment, neglect, abuse or misappropriation of resident property will be immediately removed from resident contact until the results of the investigation have been reviewed by the administrator or designee. Employees accused of alleged mistreatment, neglect, abuse or misappropriation of resident property shall not complete their shift as a direct care provider to residents. Once the administrator or designee receives an allegation of mistreatment, neglect or abuse, including injuries of unknown or source and misappropriation of resident property; the administrator will appoint a person to take charge of the investigation. The person in charge of the investigation will obtain a copy of any documentation relative to the incident and follow the resident protection investigation procedures. R23's Cognitive assessment dated [DATE] documents R23 is cognitively intact. R23's Care Plan, dated 6/4/24, documents R23 was admitted on [DATE] and has a care plan of (R23) may display pattern of voicing allegations of mistreatment by caregivers. Intervention: Investigate statements/allegation per facility protocol. Check resident for any physical marks, injury, interview persons assigned to provide care. On 8/18/24 at 11:37 AM, R23 stated I was a resident at the facility until last Friday when I moved to my own apartment. The nurse (V8, Licensed Practical Nurse) works day shift is not liked by several residents. (V8) would always hold my medications and then laugh about it. (V8) would give me a hard time, mostly with medications and then laugh when I would get upset. She would laugh about how long it would take her and I take a lot of medications. She would make me the last person but for sure if I came up and asked for my medications then she would make me wait even longer on purpose and give me mine last. I spoke to the administrator (V1, Administrator in Training) about this, and I talked mostly to the Director of Nursing (V2) and Assistant Director of Nursing. I saw them go and talk to (V8) and then they both acted funny towards me afterwards. I don't know what she told them, but they believed her over me. This happened on 8/6/24 that I told (V3) all of this. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/24 at 11:00 AM, V1 (Administrator in Training) stated I do not have any abuse allegations or investigations since I have been here. I have been here since June, and I don't have anything for Abuse. 08/19/24 1:53 PM, V10 (Certified Nursing Assistant, CNA) stated she was working on the day (R23) was very upset about (V8) being his nurse. V10 stated He would complain about (V8) all the time. The day that he was most upset was when he was in the dining room. (R23) was yelling and complained of (V8) not giving him his medication and always chooses to give them to him last. He didn't want (V8) to be his nurse. It was either the fifth or the sixth of August that this incident with (R23) happened. The ADON (V3, Assistant Director of Nursing) gave him his medication that day because he refused to have (V8) as his nurse any longer. (R23) is normally a cool and calm resident with little complaint. That day however, he was very upset, angry and emotional. He said she (V8) is evil and had been verbally abusive. The ADON (V3) was aware. She was the one who gave him his medications that day and she was down there talking to him about the situation. On 8/19/24 at 2:02 PM, V3 (Assistant Director of Nursing) confirmed she talked to R23 at some point over the last three weeks about V8. V3 stated (R23) told me (V8) would not do his insulin and blood glucose checks the way he felt they should be done. There was a personality conflict there. He would call me on the facility phone and ask me to give his medications. (R23) refused to take them from (V8) because he said he didn't trust her. When he brought this to our attention, we talked with him and with (V8) and I stopped putting her on that hall until (R23) was out of the building. (R23) would tell me I am not going to take my medications from (V8), I don't trust her. (V1, Administrator in Training) is the Abuse coordinator. He did the investigation with us (V2 Director of Nursing and V3), and we determined that we would avoid conflict and keep her off of (R23's) hall until he discharged . On 8/19/24 at 2:11 PM, V1 confirmed he did not remove the employee (V8) from resident contact, interview other residents, or complete an abuse investigation when he was informed that R23 had conflicts with V8. V1 stated (R23) stated he didn't like (V8). He said when she works his hall, he didn't like her and (R23) didn't want (V8) to give him his medications. He did not like her personality. I didn't see that as abuse.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 35509 Based on observation, interview and record review, the facility failed to serve foods as written on the menu. This has the potential to affect all 63 residents living in the facility. Findings: The Facility's Week at a Glance, dated 8/18/24, Week four, Luncheon Menu, states, Oven Fried Chicken Breast; Mashed Potatoes; Chicken Gravy; Mixed Vegetables; Roll/Margarine; Pie (menu does not specify what kind of pie as required). Residents were served: Plain Baked Chicken (no breading); Mashed Potatoes; Carrots; Bread; Strawberry Pie. On 8/18/24 at 12:35 PM, V5, Dietary Manager, stated, I don't know why the chicken was plain, carrots were served instead of mixed vegetables and bread was served instead of rolls. The frozen mixed vegetables didn't come in, but we do have canned mixed vegetables; there are frozen rolls in the freezer that could have been used. I'll talk to the cook. He's new and doesn't know things. On 8/19/24 at 10 AM, during the Group Interview with Resident Council, R3, R10, R11, R15, R29, R33, R38, all complained that often the menu will say one thing, and another will be served. R15 stated, When you ask why something on the menu wasn't what we were served, we are told that the truck didn't come in or that the cook wanted to make something else. They don't like it when you ask them about what we get to eat. On 8/18/24 at 11:45 AM, V5, Dietary Manager, stated, Yes, we write down all of the substitutions. When the substitution book was reviewed there were few entries and the Registered Dietitian had not signed off as required for the substitutions. One of the entries was Strawberries and Bananas. The substitution was Banana Pudding (which is not a substitute for a serving of fruit unless half of eight-inch banana was in each serving. This was a flavored Pudding. When asked why fruit was not substituted V5 said, oh, we did but did not specifically what the fruit was. This was not written in the substitution book. The facility's Long-Term Care Facility Application for Medicare and Medicaid Form CMS (Centers for Medicare and Medicaid Services) 671 dated 8/18/24, signed by V1, Administrator, documents 63 residents currently reside within the facility.

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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. 35509 Based on observation, interview and record review, the facility failed to ensure use of a safe sanitation solution; place food on the steam table at the appropriate time; maintain clean appliances/fixtures in the kitchen; label, date and appropriately package all opened food; use only institutional approved storage containers; date, label and discard as required, all food items in the resident's floor refrigerator. This has the potential to affect all 63 residents living in the facility. Findings: The document Food from Outside Sources/Personal Food Storage, dated 4/2017, states, Food and beverages brought in from outside sources, that are to be stored in the facility refrigerators and freezers, will be checked by a dietary staff member. Any suspicious or obviously contaminated food or beverage will be discarded immediately. Food and beverages will be labeled with the resident's name, food item and date. These foods and or beverages will be placed on a designated tray/shelf. Facility storage procedures apply. On 8/18/24 at 11:15 AM, the floor refrigerator (for resident's use) had a strong sour odor and contained the following food items: opened 2.5 ounce cheese package, no label or date; two restaurant take-out containers with a chopped chicken meal no label, that had a slimy appearance and sour odor; two plates of dried spaghetti with a sour smell; a restaurant purchased sandwich, unknown filling which was dried out, hard, loosely covered and dated 7/25/24; a murky bottle of water that slices of lemon had been added, lemon skins had turned brown, no label or date; a bag of grapes, cherries and strawberries, loosely covered, no labels of ownership or date; an unidentified glass of pink substance in the freezer without a label or date; several items in the freezer that do not have labels of resident ownership or date they were received: one pound tube of sausage; a box containing six premade cheeseburgers; Containers of grocery store labeled ice cream, opened, no label or date. On 8/18/24 at 11:30 AM, V11, Dietary Manager, and V2, Director of Nursing, confirmed that these items should have been discarded and should have been labeled with dates. V11 stated, I'm not responsible for the items that are put into the resident's refrigerator on the floor. The document In-Place Equipment, dated 4/2013, states, to mix a chlorine solution, mix at a rate of one teaspoons of bleach per gallon of water. Water temperature should be 75 degrees Fahrenheit. (For in-place equipment) the chlorine level is 100 parts per million (ppm). (note this is for in-place equipment only). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/18/24 at 9:30 AM, V20, Cook, mixed a sanitation solution. V20 opened a bottle of bleach and, using the cap, not a measuring spoon, poured chlorine into the bucket of water. The test strip was black, indicating over 200 parts per million (ppm), which is considered to be at a poisonous level. V11, Dietary Manager, instructed V20 to dump some of the water out of the bucket and add more water to it. V20 did so and when the solution was retested the level was still over the required level. V11 told V20 to dump out the solution and make another bucket of sanitation solution with a smaller amount of chlorine. When asked, V20, who speaks little English, was unable to state if he always checked the level of chlorine or what the level of chlorine tests at or should test at in the sanitation buckets. The document, Storage, dated 10/2020, states, It is the policy of this facility that food shall be stored (to) provide the best preservation. Food shall be stored at the proper temperature and for appropriate lengths of time to protect quality of food. Store (food) in covered, labeled and dated containers under refrigeration or (in the) freezer. The document, Refrigerator and Freezer Storage, dated 10/2014, states, Any item placed in the refrigerators must be covered, labeled and dated with a date-marking system that tracks when to discard perishable foods. [NAME] container with the name of the item. [NAME] the date that the original container is opened or date of preparation. Label refrigerated, potentially hazardous food with the day/date by which the food shall be consumed or discarded (maximum of seven days from time of preparation/opened). Designated Dietary employee is to check, pull and throw away any potentially hazardous foods that have been in the refrigerator longer than seven days. On 8/18/24 at 9:40 AM, the following items were in the reach in and walk in refrigerators: a 46 ounce container of thickened water, one third remaining, no label dated with marker, 7/18/24; A 46 ounce container of thickened orange juice, one half remaining no label, dated with marker, 7/20/24; one pound of cheese slices, no wrapper or container, no label or date; a five pound container of sour cream, one half remaining, no label or open date; a one pound container of Parmesan cheese, one third remaining, no label or open date. V11, Dietary Manager, confirmed these items needed labels/dates and should be discarded. I don't think some of these items (thickened liquids) need to be discarded, though. On 8/18/24 and 9:50 AM, the stock room had the following items: A large garbage can, no liner, three fourths full, was used for oats. The lid was cracked and was missing part of its rim, exposing the oats to the environment. Five cereal containers had numerous labels that had been left on. These old stickers were readable, showing various types of cereal other than what the container held. The label only stated what the item was, no open date. The flour container, one half full and a bag of streusel topping, one fourth full were not dated or labeled. An empty, scrunched Parmesan cheese container, not an institutional required container, was being used for sugar. V11 acknowledge these things stating, I will remind the staff to label and date food items. We'll need to check the dates of food. On 8/18/24 at 10:00 AM, the steam table already had the chicken, pureed chicken, ground chicken sitting in place. V20, Cook, indicated that he had put the chicken into the steam table at 8:30 AM. V11, Dietary Manager, stated that the chicken they serve comes pre-cooked and only needs to be heated before serving. V20, who speaks or understands very little English was unable to say if he routinely put foods on the steam table early. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The document Kitchen Sanitation, dated 10/2020, states, It is the policy of (this facility) to comply with Public Health Standards of Sanitation Regulations. The Food Service Manager will monitor sanitation of the Dietary Department on a daily basis. The Food Service Manager shall provide cleaning instructions for each area and piece of equipment in the kitchen. On 8/18/24 at 9:15 AM, the interior baffles and the wall of stainless steel surrounding the baffles, which is over the range, ovens, and food preparation area, had a layer of dust. The fans, blowing air directly on the food preparation area and clean dishes area of the dish machine, had a layer of black, greasy dust over the grill. V11, Dietary Manager, stated, I'll tell Maintenance to come in a clean the area. The facility's Long-Term Care Facility Application for Medicare and Medicaid Form CMS (Centers for Medicare and Medicaid Services) 671 dated 8/18/24, signed by V1, Administrator, documents 63 residents currently reside within the facility.