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	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fondulac Rehabilitation and Health Care Center	901 Illini Drive East Peoria, IL 61611

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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 0628 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow their own discharge policy for discharging a resident for one resident (R5). This failure led to R5 being discharged to a home with no running water, with all of R5's medical supplies being left in the weather elements and being ruined, no food in the home and no home health assistance as ordered by the doctor. The failure of leaving R5's medical supplies on the porch has the potential for R5 to get infections in wounds that could lead to hospitalizations, serious illness or even death. The failure to have no home health set up for home could lead to multiple health concerns worsening and causing illness, hospitalizations and death. The Immediate Jeopardy began on 3/31/26 at unknown time when R5 was transported home with all of his belongings left on the front porch with no home health set up for assistance with anything. V1 (Administrator) was notified of Immediate Jeopardy on 5/15/26 at 11:54 AM. The immediacy was removed on 5/15/2026 the facility remains out of compliance at a severity Level 2 while the facility evaluates the effectiveness of their removal plan. R5's Medical Record documents he was admitted on [DATE] with diagnosis to include but not limited to Chronic Respiratory Failure with Hypoxia, Chronic Peripheral Venous Insufficiency, and Type II Diabetes Mellitus. R5's Medical Record documents that he was cognitively intact and made all of his own decisions. On 5/15/2026 V6 (Social Service Director at Local Police Department) stated that R5 called the police department on 4/1/2026 (1 day after discharge) because all of his belongings were on the front porch and it was raining, V6 stated upon arrival to R5's homes she discovered all of his bandages were ruined because they were on the front porch. V6 stated R5 had no running water or food at his house and did not have any home health, friends or family to assist him.On 5/15/2026 R5 stated I was promised home health help and I did not get that. They (staff) dumped my stuff on the porch and said see ya later. They did not like me, no one there (at the facility) did. On 5/13/2026 V8 (Social Services Director) confirmed that she did not set up any home health assistance for R5, V8 stated she was on vacation when R5 left. (R5) never knew what he wanted. He just didn't want to pay the bill for sure. On 5/13/2026 V2 (Director of Nursing) confirmed that she did not set up any home health or do any safety screening or questions with R5. (V8/Social Services Director) should do all of that. On 5/15/2026 V7 (Certified Nurse Aide) confirmed that she was the staff member who drove R5 home on 3/31/2026. V7 (CNA) confirmed she put all of his stuff including some medical stuff on his front porch. V7 (CNA) confirmed she had worked with R5 during his stay at the facility and V7 stated that she did not believe that R5 had the ability to move his belongings inside by himself. On 5/15/2026 V9 (R5's Doctor/Medical Director) stated he wrote for R5 to discharge home with home health, I would not have wrote it if I didn't think he really needed it. V9 stated All conditions for safety must be met before a resident is left alone after discharge. R5's last care plan dated 3/9/26 documents Long term stay in facility is anticipated. R5's medical record does not contain any discharge planning, discharge assessment, recapitulation of stay for R5, disposition of his belongings and/or medicine.On 5/15/2026 V1 (Administrator) confirmed there was no documentation of any discharge planning or any indication that R5 discharged home and on what date. The Facility's Discharge Summary and Plan policy dated 8/2025 documents The (continued on next page)

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

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F 0628 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	discharge plan will include resident and family/caregiver educations needs and will initiate or maintain collaboration between the nursing facility and other post-acute providers to support the resident's transition to community living. The Discharge Plan, Instructions and Summary provides a recapitulation or summary of the resident's stay. Documentation of discharge plan will be completed utilizing the Interdisciplinary Care Conference Note 48 Hour Meeting assessment by Social Service director or Social Service Designee. Social Service Director or Social Service Designee will initiate and upgrade the discharge plan in the Care Plan section of the resident's record. The Facility's Discharge Summary and Plan policy dated 8/2025 documents Discharge Education a. Nurse will review discharge instructions and medications with resident/resident representative. Copy of Disposition of Medication form will be given to resident/resident representative and a copy scanned into the record. b. Social Services Director or designee will include the Discharge Plan, Instructions, and summary in the Discharge Packet. 6. Nurse will document discharge note in the progress notes section of the resident record Discharge note will include-skin assessment, who they discharged with, where they are discharging to, what belongings were sent with them and other pertinent information. The Facility's Discharge Summary and Plan policy dated 8/2025 documents Social Services or designee will make post discharge follow up call with the discharged resident 48 hours after discharge. If there are identified concerns during this call, Social Services or designee should continue post discharge follow up calls daily until the concerns are resolved. The Post Discharge Call Follow up UDA must be completed by Social Services, or designee to document the outcome of each call.The Facility submitted an Abatement plan on 5/15/2026 at 1:57 PM. The Facility's Abatement plan was accepted on 5/15/2026 at 2:22 PM. On 5/15/26 the surveyor confirmed through record review and interview that the following steps were taken to remove the immediacy: On 5.15.26, Administrator and SSD called R5 to discuss discharge and if any services are still needed. On 5.15.26, Social Service Director and BOM completed a home visit on R5 to ensure their safety. On 5.15.26, Social Services Director called all discharges since 3/30/26 to ensure discharge was successful On 5.15.26, SSD, DON, MDS, and Admin conducted audit of all discharges in the last 30 days to ensure needs are met. On 5.15.26, Ad Hoc QAPI completed and Medical Director notified of deficiencies. On 5.15.26, Discharge review checklist was created to be utilized for all future discharges. On 5.15.26 IDT team was educated on Discharge policy and procedure. On 5.15.26, Administrator in serviced Social Services Director on ensuring discharge requirements are made prior not resident discharging from facility.Immediate action(s) taken to ensure discharge planning process is followed: On 5.15.26, Discharge Policy and procedure was reviewed to ensure compliance. On 5.15.26, IDT Team was educated on discharge policy and procedure. On 5.15.26, IDT was educated on discharge checklist completion prior to discharge. On 5.15.26, IDT Team completed a review of all discharges in the last 30 days and current planned discharges to ensure compliance.Immediate action(s) taken to ensure the discharge process has been properly communicated with residents and providers for a safe discharge: On 5/15.26, Social Services Director called all discharged since 3.30.26 to ensure discharge was successful. On 5.15.26, Administrator in-service IDT on ensure education was completed for discharging residents. On 5.15.26, DON inservced RN's/LPN's on completing discharge education.Immediate action(s) taken to ensure a QAA process is in place for safe discharges: On 5.15.26, Ad Hoc QAPI was completed with IDT to review process and deficiencies. On 5.15.26, Administrator in-serviced IDT on discussing all discharges during morning stand-up meeting. On 5.15.26, Administrator in-serviced IDT on discharge checklist.Abatement completion date: 5/15/26

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure accuracy of the plan of care for one resident (R5) of three resident's reviewed for care plan accuracy. R5's Medical Record documents that he was admitted on [DATE] with diagnoses to include but not limited to Chronic Respiratory Failure with Hypoxia, Type II Diabetes Mellitus and Chronic Peripheral Insufficiency. R5's Medical Record documents he was cognitively intact and made all of his own decisions. R5's care plan dated 3/9/26 documents focus areas as (R5) has a behavior problem relating to false accusations. (R5) refuses showers and will tell other staff no shower was offered. The resident has mood problem, he has delusional thoughts, he will state everyone is against him, if you don't agree with him, he thinks you are calling him a liar. These care plans were entered by V2 (Registered Nurse/Director of Nursing). On 5/15/2026 V2 (RN/DON) denied knowledge of the care plan focus areas on 3/9/26. I have to sign a lot of care plans. On 5/15/2026 V10 (Licensed Practical Nurse/Care Plan Coordinator) stated she was the person who initiated the 3/9/26 care plan entries. V10 (LPN) could not provide an investigation or any supporting documentation of R5 making false accusations. On 5/15/26 both V2 (RN/DON) and V10 (LPN) confirmed neither one of them had ever investigated any accusations made by R5. V10 stated she was told by staff that R5 lies. The Facility's undated Care Planning policy documents Every resident will have a comprehensive Plan of Care for each resident that will assist a resident in achieving and maintaining the highest practical level of mental functioning, physical functioning, and wellbeing as possible.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure fall assessments were done and accurate for 4 residents (R1, R4, R11, R12, failed to document any follow up assessments after a fall for one resident (R11), provide adequate supervision while showering for one resident (R4), and failed to assess the safety of residents who request to shower independently for five residents (R8, R9, R10, R11, R12). These failures led to R1 falling and breaking her hip, requiring surgery and an increase in need for assistance with Activities of Daily Living. These failures led to R4 being left alone in the shower with no assistance then falling and breaking her arm. On 5/20/2026 V11 (Licensed Practical Nurse), V12 (Certified Nurse Aide) and V18 (Certified Nurse Aide) described an independent shower resident as a resident that staff will turn the shower on to warm it up, set out towels and wash cloths and let the resident know to go take a shower. V11 (LPN), V12 (CNA) and V18 (CNA) all agreed that when a resident is an Independent shower that staff would answer other call lights and do other duties and check on the resident every once in a while. 1.R1's Medical Record documents that she was admitted to the facility on [DATE] after she had a pacemaker put in. R1's admission Nursing assessment dated [DATE] documents that R1 planned on doing therapy for strengthening and then return home. R1's Medical Record documents that she was alert and could make her own health care decisions but did defer to her family often.R1's Nurse's Note dated 3/9/2026 document that on 3/8/2026 at 11:40 PM R1 walked into the hallway from her room and appeared to lose her balance and fell onto her right side. R1's notes document she was sent to the hospital and admitted for surgery to repair a right broken hip. R1's Medical Record did not contain a care plan or fall risk assessment until 3/9/2026 (morning after fall with fracture). On 5/19/2026 V10 (Licensed Practical Nurse/Care Plan Coordinator) confirmed there was no care plan or fall risk assessment for R1 until 3/9/26. V10 (LPN) stated she didn't know why there was no documentation of fall risk assessment or care plan for fall prevention. On 5/20/26 V2 (Registered Nurse/Director of Nursing) confirmed there was no assessment of R1's fall risk and no care plan of any fall prevention interventions prior to R1 falling and fracturing her hip on 3/9/26. V2 confirmed there should be both in R1's record upon admission.On 5/20/2026 V20 (Registered Nurse who was on duty during R4's fall on 3/8/26) stated (R1) was a new admission. I can't recall any specific fall interventions in place. V20 (RN) stated (R1) would sometimes toilet herself (without assistance) even though she shouldn't. V20 (RN) stated R1 should not be toileting herself without assistance due to a lot of fall risks that (all elderly) have. V20 (RN) stated that R1 used her call light when she wanted to. On 5/19/2026 V23 (R1's family member) stated that it didn't seem like the facility was ready for R1 when she actually arrived on 3/5/2026. No one seemed to know what was going on. The hospital always told us that (R1) was a high fall risk. V23 stated she did not see any signs of any fall precautions in place for R1, and then I get a call she fell and broke her hip, I don't feel like they (facility) know how to take care of people. 2. R4's Medical Record documents R4 was admitted on [DATE] after a fall at home. R4's Medical Record includes diagnoses Type II Diabetes Mellitus, Crohn's Disease and Chronic Atrial Fibrillation. R4's Medical Record documents that R4 is alert and able to make all of her own decisions. The Facility's undated Final Report documents that on 4/9/2025 (R4) states she lost her balance while taking a shower. X-Ray orders obtained from (V9/Doctor) show left humerus fracture, send resident to ED (Emergency Department) for evaluation and treatment. On 5/19/2026 V1 (Administrator) stated that the results of the investigation into R4's fall showed that R4 was left alone in the shower because she preferred showering alone. V16 (Certified Nurse Aide)'s written/signed statement dated 4/9/26 documents that V16 left R4 in the shower unsupervised because R4 stated she doesn't have anyone in there with her when she showers. R4's Medical Record does not contain any documented request to shower alone, safety risk assessment or education of R4 about the risk of falling if left unsupervised.On 5/15/2026 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R4 confirmed she was alone in the shower on 4/9/2026 when she fell and broke her arm. R4 stated she didn't know why no one was in the shower room with her. I expect they had other things to do. R4's Discharge Summary from hospital dated 2/4/26 documents Previously independent: reports multiple falls over the past year. Recent fall which brought her to (hospital) patient hit head, states she was turning around and fell. R4's admission Fall Risk Data Collection dated 2/10/2026 signed by V10 (Licensed Practical Nurse/Care Plan Coordinator) documents Fall History: 0. No History and vision Pattern 0. Adequate-able to see in adequate light. The Fall Risk Data Collection documented R4 was Low Risk for falls.On 5/19/2026 V10 (LPN/CPC) confirmed that R4's admission Fall Risk Data Collection dated 2/10/2026 was marked wrong. Should have been yes to falls and No to adequate vision per other documentation in R4's medical record. V10 (LPN/CPC) confirmed that those changes would have made R4 High Risk for falls instead of Low Risk.On 5/19/26 V10 (LPN/CPC) confirmed that R4's Care Plan did not include any fall risk assessment or interventions until 4/10/2026 (1 day after fall with fractured arm). 3. R11's Medical Record documents that he was admitted on [DATE] with diagnoses to include but not limited to Chronic Obstructive Pulmonary Disease, Hypertension and Depression. R11's Medical Record documents that he is alert and oriented and makes all of his own decisions. R11 refused to be interviewed throughout the survey. R11's Fall Risk Data Collection dated 3/18/26 documents Medication use and lists categories of medications: Antihistamines, Diuretics, Hypoglycemic agents, Antiseizure/Antiepileptics, Antihypertensive, NSAIDS (Non-Steroidal Anti-Inflammatory Drugs), Benzodiazepines, Narcotics, Psychotropics, Anti-Parkinson's, Cathartics, Sedatives/Hypnotics. None of these boxes were checked. R11's Medication Administration Record dated March 2026 document that he received the following medications Metformin (Hypoglycemic Agent) 500 mg (milligram) every day, Hydrocodone (Narcotic) 5-325 mg twice daily and Trazadone (Sedative/Hypnotics) 150 mg every night.On 5/20/26 V10 (LPN/CPC) confirmed that none of the medications were marked on the fall risk assessment. I guess I didn't see those (medications) on the MAR (Medication Administration Record) in March. V10 (LPN/CPC) confirmed that those medications would have increased R11's fall risk score. On 5/20/2026 V11 (Licensed Practical Nurse) and V18 (Certified Nurse Aide) confirmed that R11 is considered an independent shower. On 5/20/2026 V2 (Registered Nurse/Director of Nursing) confirmed that there was no documentation in R11's medical record that R11 requests to shower alone. V2 (RN/DON) confirmed there was no care plan or interventions in place for R11 to shower without supervision. 4. R12's Medical Record documents that he was admitted on [DATE] with diagnoses to include but not limited to Hypertension, Schizoaffective Disorder and Mixed Hyperlipidemia. R12's Medical Record documents that he is alert and oriented and makes his own decisions. R12's Fall Risk Data Collection dated 3/12/26 documents Medication use and lists categories of medications: Antihistamines, Diuretics, Hypoglycemic agents, Antiseizure/Antiepileptics, Antihypertensive, NSAIDS (Non-Steroidal Anti-Inflammatory Drugs), Benzodiazepines, Narcotics, Psychotropics, Anti-Parkinson's, Cathartics, Sedatives/Hypnotics. None of these boxes were checked. R12's Medication Administration Record dated March 2026 documents that R12 received Lasix (Diuretics) 60 mg twice daily, Olanzapine (Psychotropic) 10 mg every night and Metoprolol (Antihypertensives) 25 mg twice daily.On 5/20/2026 V2 (Registered Nurse/Director of Nursing) confirmed that R12's Fall Risk Data Collection was marked incorrectly and that the addition of the medications would have changed his fall risk assessment score. R12's Nurse's Notes dated 2/26/26 at 4:30 AM documents resident was found on the floor on face down and had a raised area on forehead.On 5/20/2026 V2 (RN/DON) confirmed that there was no further assessment such as condition of the injury to forehead or physical assessment documentation for R12 at all in R12's Medical Record. R12's Nurse's Notes dated 2/27/26 documents that R12 was upset and entered his room and began screaming that he was on the floor and staff entered room to find resident on the floor. Immediate Action Taken: DON notified. MD/medical doctor faxed. (R12) in (wheelchair) for time being. On 5/20/2026 V2 (RN/DON) confirmed that there was no actual physical assessment of R12 documented and that there was no follow up monitoring of R12 for 72 hours as per facility policy. V2 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	(RN/DON) stated she wasn't sure if R12 always used the wheelchair now or if he continued to attempt to walk. Throughout the survey R12 propelled himself in a wheelchair and transferred himself independently. R12 declined to be interviewed during survey process. On 5/20/2025 V11 (LPN) V12 (CNA) and V18 (CNA) stated R12 is considered to be independent to shower. 5. On 5/20/2026 V11 (LPN), V12 (CNA) and V18 (CNA) reported that R8, R9 and R10 were all considered to be independent showers. On 5/20/2026 V2 (RN/DON) confirmed that R8, R9 and R10 had documented request to shower alone, safety risk assessment to do so or care plan interventions to enable R8, R9 and R10 to shower independently. The Facility's Skilled Fall Policy dated 5/2025 documents The community shall ensure that the Fall Program is maintained to reduce the occurrence of falls, reduce risk of injury, and promote independence and safety. Each resident residing at this facility will be provided services and care that ensures that the resident's environment remains as free from accident hazards as is possible and each resident receives adequate supervision and assistive devices to prevent accidents. The Facility's Skilled Fall Policy dated 5/2025 documents Staff must complete root cause analysis to determine why the resident fell. A progress note must be documented in the resident's record, including root cause analysis, resident provider notification, resident representative notification, details if injury is present, new intervention, pertinent statements, and any other details surrounding the resident's fall. Post-fall documentation must be done every shift for 72 hours following the fall.