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	06/24/2026

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

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure call lights were answered in a timely manner and failed to follow its Call Light Policy for one (R1) resident reviewed for call lights in the sample of 14 when R1's call light was not answered in a timely and efficient manner after R1 requested assistance due to pain and wanting to return to bed. Findings include:R1's nursing progress note, dated 5/18/26 at 11:39 AM, showed V2/DON/Director of Nursing documented R1's mother reported R1 had his call light on for 40 minutes and was in pain wanting to be put back in bed. The note documented the CNA/Certified Nursing Assistant was waiting for someone from another hall to assist with transferring R1 back to bed. The record did not show an assessment of R1's pain level at that time, did not show documentation of an intervention to relieve R1's pain, and did not show documentation that R1 was timely assisted back to bed.On 6/17/26 at 11:40 AM, R1 stated that approximately three days after admission, on 5/18/26, he was in his wheelchair in pain and wanted to go back to bed. R1 stated he pressed the call light with no response, attempted to call the facility's phone number with no answer, and then called V14/R1's Family Member for assistance.On 6/18/26 at 11:28 AM, V14 stated she received a phone call from R1 on 5/18/26. V14 stated R1 told her his call light had been on while he was left in his wheelchair in pain and no one answered the call light for over an hour. V14 stated R1 then attempted to call the facility and could not get through, so he called her. V14 stated this was one of R1's first times up in the chair after the wreck, injuries, and hospitalization, so she was concerned for his safety because she was three hours away. V14 stated she called the facility and spoke with V2/DON. V14 stated V2 told her R1 would have to wait because he required two people to transfer and one CNA on the hall was on break.On 6/18/26 at 12:35 PM, V2/DON stated she did tell V14 that R1 was going to have to wait. V2 stated she did not offer to go down and told the nurse and CNA taking care of R1 that shift. V2 stated, I assumed they would take care of it.The facility policy titled, SNF (Skilled Nursing Facility) Call Light Policy & Procedure, approved 7/2025, documented resident call lights will be answered in a timely and efficient manner once engaged. The policy documented call lights are answered based on first engaged and urgency of resident need, call lights shall be within reach, and if a resident requires an alternative call light device, the facility will provide and care plan for the needed device.The facility document titled, Certified Nursing Assistant/CNA Job Description, undated, documented CNAs are responsible for assisting residents with daily needs, ADLs (Activities of Daily Living), personal hygiene, answering call lights promptly, keeping residents dry, following care plan approaches, implementing positioning and transfer techniques, and promoting resident rights.

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

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	06/24/2026

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

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record the Facility failed to verify and document personal inventory items for one resident (R3) reviewed for discharge in a sample of 14.Findings include:R3's Physician Order Sheet/POS, dated 6/18/26, documents R3 admitted to the facility on [DATE] with diagnoses including Compression Fracture of the T11-T12 Vertebrae and Low Back Pain. The POS documents an order dated 7/20/25, for a Shoulder-Thoracic-Sacral/STS back brace.R3's Nursing Progress Notes (dated 4/5/26 at 8:06 am and 4/6/26 at 6:35 am), document R3 is in the hospital.R3's Nursing Progress Note, dated 5/15/26 at 10:51 am, documents a late entry follow up with family and sister has decided to have (R3) admitted to another facility closer to her.R3's Nursing Notes, dated 4/5/26 through 5/15/26, do not document R3's personal inventory items/belongings were sent upon R3's discharge and do not document follow up telephone calls with V24 (R3's Sister/Power of Attorney).On 6/17/26 at 8:51 am, V24 (R3's Sister/Power of Attorney) stated, My sister (R3) discharged and went to the hospital, then never went back to the facility, because we put her in a different facility. The new facility called and spoke to someone at the old facility about (R3's) wheelchair and back brace, and they told her that they did not have it. When my sister (R3) went to the hospital, I went to the facility to get her belongings and no one was around to help, so I packed up the clothing items that were in her drawers and could not find the wheelchair or brace. (R3's) insurance had paid for that wheelchair and on a former hospital visit, the hospital had given (R3) the back brace before being admitted to the facility. I called the facility, and no one could locate either of them.On 6/23/26 at 2:21 pm, V19 (Certified Nursing Assistant) stated, We fill out the inventory sheets and give them to the nurse. I am not sure where they go after that. If families bring in new clothing or items, we are supposed to write them on the inventory sheets.On 6/18/26 at 11:10 am, V2 (Director of Nursing) stated, I cannot find an inventory sheet for (R3), and I do not see that anything is documented in the progress notes for (R3's) personal items. It is the nursing staff responsibility to record personal belongings on the inventory sheet.On 6/18/26 at 8:50 am, V1 (Administrator) stated, After (R3) discharged , (V24) called us and asked if we had (R3's) belongings, we talked with (V24) and told (V24) that the wheelchair that (R3) was using was the facility wheelchair. When (R3) originally admitted , R3 had a wheelchair with (R3's) name on the back and we thought that (V24) took that wheelchair home because we could never find it. (R3) also admitted with a back brace and we also assumed that (V24) had taken that also, because we never found any of those items.The Facility Discharge Summary and Plan Policy, dated 8/2025, documents: the discharge plan will include resident and family collaboration to support the resident's transition to community living; nurse will document a discharge note in the progress notes section of the resident record and include what belongings were sent with them; and Social Services/Designee will make a post discharge follow up call with the discharged Resident 48 hours after discharge and if there are identified concerns during this call, Social Services/Designee should continue post discharge follow up calls until the concerns are resolved and document the outcome of each call.

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	06/24/2026

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

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and record review the Facility failed to guarantee Residents reasonable telephone access by not providing phone service access for family members to contact residents for four residents (R1, R3, R6, and R14) reviewed for telephone communication in a sample of 14.Findings include: 1. On 6/17/26 at 8:51 am, V24 (R3's Sister/Power of Attorney) stated, I have called and left numerous messages, and no one returns my phone call or the phone just rings and rings, and no one answers it. This has happened on multiple occasions. My sister (R3) discharged from the facility and I called looking for personal items and no one ever calls me back. 2. On 6/17/26 at 9:06 am, V25 (R14's Granddaughter) stated, I have called my grandmother so many times, and the phone just rings and rings. When they answer, sometimes I am on hold for over twenty minutes. They have no cordless or portable phones, so that does not help either, if they are busy, they have to run up the hallway to the nurse's desk to answer the phone. At night, the nurses and aides must answer the phones, and they are just too busy sometimes to answer the phones. 3. On 6/17/26 at 11:40 AM, R1 stated he tried to call the facility before to get help and could not get anyone to answer the phone. It's usually in the evenings when friend or family have tried calling and cannot get through. 4. On 6/18/26 at 8:55 AM, R6 stated everybody has issues with getting phone calls here. It is not usually during the day, but after 4:00 PM is iffy to get a phone call because nobody is in the office and staff are busy in the evenings. Nobody really answers the phone after 4:00 PM. On 6/18/26 at 11:28 AM, V14/R1's family member stated, (R1) attempted to call the facility with his call light on needing assistance one day and could not get through to anyone, so he had to call me and I had to call the building myself to get ahold of someone. On 6/18/26 at 9:55 AM, V1/Administrator stated he was made aware of an issue about a month ago with a resident's family member not being able to get through to the facility after hours. Medical Records is responsible for answering the phone during the day between the hours of 7:30 AM and 4:00 PM Monday through Friday. Clinical staff, including nurses and Certified Nursing Assistants are responsible for answering the phone after hours. There are no mobile or cordless phones for staff, only the phones at the nurse's stations on the halls and in the offices. There is no full-time receptionist. Medical Records is not here today so managers and nurses will answer the phones today. On 6/23/26 at 12:20 PM, V/21 Medical Records/Receptionist stated she answers the phone when present Monday through Friday between the hours of 7:30 AM and 4:00 PM and after hours the calls go to the clinical staff. Family call sometimes in the morning when I get here and state that they could not get anyone to answer after I left. There are times I come in and there are 50 or more missed calls on the phone. We don't have a voicemail box set up to leave a message, so they would have to call back during the day to follow up. The Resident Rights for People in Long-Term Care Facilities, dated 11/2018, documents: right to make own choices; must treat you with dignity and respect and care for you in a manner that promotes quality of life; must provide equal access to quality care regardless of diagnoses or (continued on next page)

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	06/24/2026

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

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	condition; must provide services to keep physical and mental health at their highest practical levels; should be provided services and/or items included in plan of care; and you have the right to make and receive phone calls in private and to have access to use of a telephone where calls can be made without being overheard. The Facility Wide Assessment, dated 1/1/26, documents: the facility assessment must include an evaluation of the overall number of facility staff needed to ensure a sufficient number of qualified staff are available to meet each resident's needs; and facility documents administration needs. The Facility Resident Rights Policy, dated 12/2024, documents: has the right to a dignified existence; and access to persons and services inside and outside of the community. The Facility Receptionist/Clerk/Administrative Assistant Job Description, undated, documents: responsible for interpreting company policies; answer telephone and directs caller to correct station, takes messages, answers questions of callers; cooperates with facility personnel to ensure services can be adequately maintained to meet needs of the residents; and understands, upholds and promotes the rights of the residents.

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	06/24/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received necessary care and services to maintain their highest practicable physical, mental, and psychosocial well-being for one resident (R1) in a sample of 14 reviewed for abuse and neglect. These failures resulted in R1 experiencing avoidable pain, fear, distress, discomfort, and humiliation when left waiting in a wheelchair while in pain, left in stool despite being able to make needs known, and left suspended in a mechanical lift sling instead of being promptly transferred and repositioned for comfort and safety. Findings include:R1's admission record documented R1 was a [AGE] year-old admitted to the facility on [DATE] from a local hospital with diagnoses including fusion of cervical spine, occipital condyle fracture, chronic pain syndrome, stiffness of the right shoulder and elbow, muscle wasting and atrophy, dysphagia, and lack of coordination.R1's hospital discharge records, dated 5/15/26, documented R1 was discharged from a local hospital to the facility on 5/15/26 after hospitalization from 4/10/26 to 5/15/26 related to a motorcycle accident. The records documented multiple traumatic injuries and post-surgical needs, including cervical spinal fusion, multiple fractures, mobility restrictions, braces/splints to extremities, anticoagulation therapy, and pain management medications.R1's nursing progress note, backdated to 5/15/26 at 10:35 AM, documented R1 arrived via ambulance with a family member, was alert and able to make needs known, and had multiple fractures including acetabulum, wrist, and skull fractures. The note documented R1 was non-weight bearing to the right upper extremity, left upper extremity, and right lower extremity, and weight bearing as tolerated to the left lower extremity for transfers only.R1's Social Service note, dated 5/15/26 at 2:42 PM, documented R1 was admitted from a local hospital after a motorcycle accident, was currently unable to use his arms, and was independent with decision making.R1's nursing progress note, dated 5/18/26 at 11:39 AM, showed V2/DON documented R1's mother reported R1 had his call light on for 40 minutes and was in pain wanting to be put back in bed. The note documented the CNA was waiting for someone from another hall to assist with transferring R1 back to bed. The record did not show an assessment of R1's pain level at that time, did not show documentation of an intervention to relieve R1's pain, and did not show documentation that R1 was timely assisted back to bed.On 6/17/26 at 11:40 AM, R1 was observed in his room awake, alert, and able to make his needs known. R1 stated he arrived at the facility on 5/15/26 around 10:00 AM. R1 stated no one came to his room until a few hours later. R1 stated when he later switched rooms, the beds in the new room had to be switched because they were not functioning. R1 stated staff transferred him from his wheelchair with a mechanical lift and sling before realizing the beds needed to be switched. R1 stated he was left suspended in the mechanical lift sling for approximately 15 minutes while staff switched the beds. R1 stated no staff members were present while he was suspended in the mechanical lift sling.On 6/17/26 at 11:40 AM, R1 stated that approximately three days after admission, on 5/18/26, he was in his wheelchair in pain and wanted to go back to bed. R1 stated he pressed the call light with no response, attempted to call the facility's phone number with no answer, and then called V14/R1's Family Member for assistance.On 6/17/26 at 11:40 AM, R1 stated that a few weeks prior at night, he had his call light on due to having a bowel movement and had to lay in the bowel movement with the call light on for over two hours before receiving assistance. R1 stated, I'm 26-years-old and shouldn't have to lay in my own feces like a child. That's humiliating and disgusting.On 6/18/26 at 12:24 PM, V15/R1's Family Friend stated she followed R1 in the ambulance to the facility on 5/15/26 and stayed with him from approximately 10:00 AM until 6:00 PM because she did not want to leave R1 at the facility after the day unfolded. V15 stated R1 sat in the initial room until approximately 2:00 PM without seeing anyone. V15 stated R1 did not want to stay after the first four hours, and they called the non-emergency line to transfer R1 to a different facility. V15 stated, I was crying it was so bad. (continued on next page)

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	06/24/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	V15 stated two staff came in and offered to move R1 to a new room, and R1 was left suspended in the mechanical lift sling for about 15 minutes while staff switched out beds in the new room. V15 stated one bed was a crank bed, and the other bed did not work. V15 stated R1 complained his neck hurt and he was in obvious pain while in the lift. V15 stated R1 did not receive medications, including pain medication, no vitals were completed, and no nursing assessment was performed while she was present from approximately 10:00 AM until 6:00 PM.On 6/18/26 at 11:28 AM, V14/R1's Family Member stated R1 and V15 told her R1 was left in the air in a sling for approximately 15 minutes during transfer from the wheelchair to the bed while staff switched the beds. V14 stated R1's legs were going numb, R1 was in pain, and R1 was yelling out for help with no one around.On 6/18/26 at 11:28 AM, V14 stated she received a phone call from R1 on 5/18/26. V14 stated R1 told her his call light had been on while he was left in his wheelchair in pain and no one answered the call light for over an hour. V14 stated R1 then attempted to call the facility and could not get through, so he called her. V14 stated this was one of R1's first times up in the chair after the wreck, injuries, and hospitalization, so she was concerned for his safety because she was three hours away. V14 stated she called the facility and spoke with V2/DON. V14 stated V2 told her R1 would have to wait because he required two people to transfer and one CNA on the hall was on break.On 6/18/26 at 12:35 PM, V2/Director of Nursing stated CNAs should not leave a resident suspended in a mechanical lift sling unattended or for prolonged periods of time. V2 stated she would expect staff to transfer the resident back to the chair and not leave the resident in the mechanical lift.On 6/18/26 at 12:35 PM, V2/DON stated she did tell V14 that R1 was going to have to wait. V2 stated she did not offer to go down and told the nurse and CNA taking care of R1 that shift. V2 stated, I assumed they would take care of it.R1's Nursing Admission/re-admission Data Collection showed an opened date of 5/15/26 at 6:01 PM, approximately eight hours after admission, and a locked date of 5/16/26 at 11:02 AM. The assessment documented R1 was not assessed by a nurse until 6:01 PM on 5/15/26 and the assessment was not completed until 5/16/26 at 11:02 AM.On 6/18/26 at 12:35 PM, V2/Director of Nursing stated an admission nursing assessment should be done in a timely manner, and she would expect it to be done within four hours to obtain a baseline picture of the resident. V2 confirmed the admission nursing assessment was not locked until 5/16/26 when V2 locked the assessment.On 6/18/26 at 2:20 PM, V3/Licensed Practical Nurse stated she worked second shift on 5/15/26 and completed R1's admission assessment after 6:00 PM to help her coworker. V3 stated there was a lot of passing on between nurses related to the admission and that was another reason the assessment was completed late. V3 stated, The assessment should have been completed sooner, but we were busy.On 6/18/26 at 2:30 PM, V9/Registered Nurse stated she was the nurse assigned to R1's original room assignment hall on 5/15/26 and received report from the hospital. V9 stated she did not assess R1 because she was busy entering medication orders. V9 stated, I did not do any vital signs or assessments on R1 when he got here. I only put a note in stating that he arrived at the building.R1's vital sign records showed R1 had only one documented set of vital signs after admission. Blood pressure was documented on 5/15/26 at 6:07 PM as 140/79 mmHg; temperature on 5/15/26 at 6:08 PM as 97.4 degrees Fahrenheit; respirations on 5/15/26 at 6:08 PM as 16 breaths per minute; pulse on 5/15/26 at 6:18 PM as 78 beats per minute; and oxygen saturation on 5/15/26 at 6:19 PM as 98% on room air. R1's electronic health record did not include any additional documented blood pressure, temperature, pulse, respirations, or oxygen saturation monitoring after 5/15/26 through 6/17/26, despite R1's recent hospitalization, multiple fractures, cervical spinal fusion, pain medication use, anticoagulant use, immobility, and need for skilled nursing observation and assessment.R1's current physician order summary, dated 6/17/26, did not include orders to monitor vital signs or pain level.On 6/23/26 at 10:35 AM, V9/Registered Nurse, V22/Licensed Practical Nurse, and V23/Licensed Practical Nurse stated all residents should have a pain assessment completed every shift and residents receiving skilled nursing care should have vital signs completed every shift. V9, V22, and V23 confirmed R1 did not have orders for vital signs or pain assessments and confirmed R1 had no (continued on next page)

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	06/24/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	vital signs entered since 5/15/26 and had multiple occasions with several days between pain assessments.On 6/23/26 at 11:15 AM, V2/Director of Nursing stated there was nothing in R1's care plan or orders about pain or vital signs. V2 confirmed R1 did not have vital signs documented since admission and had holes of multiple days in pain assessments. V2 stated nurses should complete vitals and pain assessments with skilled nursing assessment at minimum daily, but mostly every shift, and they were not completing them.The facility failed to follow its Vital Sign Policy when it failed to obtain and document vital signs according to R1's condition and needs after admission.R1's physician order summary showed orders for hydrocodone-acetaminophen, oxycodone, acetaminophen, methocarbamol, non-weight-bearing status, brace/splint use, passive range of motion, therapy, and CPM (Continuous Passive Motion) machine use.R1's pain level summary showed R1 had ongoing moderate to severe pain, including pain scores of 9/10 on 5/18/26, 7/10 on 5/21/26, 7/10 on 5/22/26, 10/10 on 6/4/26, 9/10 on 6/8/26, and 10/10 on 6/17/26. The pain record showed multi-day gaps without documented pain assessments, including gaps from 5/18/26 to 5/21/26, 5/22/26 to 5/29/26, 5/29/26 to 6/4/26, and 6/12/26 to 6/17/26.The facility failed to follow its Pain Management policy, which required pain assessments at least every shift, when R1 had multi-day gaps without documented pain assessments despite repeated moderate to severe pain, multiple traumatic injuries, cervical spinal fusion, chronic pain syndrome, immobility, and prescribed pain medications.R1's daily skilled nursing notes dated 5/17/26, 5/18/26, 5/19/26, 5/20/26, 5/21/26, 5/31/26, 6/2/26, 6/5/26, and 6/10/26 documented R1 required skilled services including nursing observation and assessment, management of the care plan, therapy, medication management, and/or teaching and training. The notes identified the reason for skilled services as motor vehicle accident, multiple fractures, immobility, pain, therapy, and/or wound care.R1's electronic health record showed R1 was continent of bowel in daily skilled nursing notes and was able to make needs known. R1 required extensive staff assistance due to multiple fractures, non-weight-bearing restrictions, braces, immobility, and pain.The facility failed to ensure timely toileting/incontinence care for R1, which resulted in R1 being left in stool despite being continent of bowel and able to communicate needs. This caused humiliation, distress, and discomfort for R1.The facility failed to ensure R1 received necessary care and services after admission from the hospital with multiple fractures, cervical spinal fusion, chronic pain syndrome, immobility, pain medication use, and weight-bearing restrictions. The facility's failures resulted in actual harm to R1, including prolonged pain, fear, distress, discomfort, and humiliation.The facility policy titled, The Resident Rights for People in Long-Term Care Facilities, dated 11/2018, documented residents have the right to make their own choices, be treated with dignity and respect, receive care that promotes quality of life, receive equal access to quality care, receive services to keep physical and mental health at their highest practicable levels, and receive services/items included in the plan of care.The facility policy titled, Facility Resident Rights Policy, dated 12/2024, documented residents have the right to a dignified existence and access to persons and services inside and outside of the community.The facility policy titled, Pain Management, dated 2/2025, documented each resident has the right to optimal pain assessment and management. The policy documented unrelieved pain can have adverse psychological and physiological effects, and pain management enhances healing and promotes physical and psychological wellness. The policy documented pain assessments were to be completed at least every shift.The facility policy titled, Vital Sign Policy, approved 4/2026, documented vital signs should be obtained according to the resident's service plan, as determined by the resident's healthcare provider, and frequency may vary based on the resident's condition and needs. The policy documented vital signs should be recorded in the medical/electronic health record with the date, time, and staff member's name.The facility policy titled, SNF (Skilled Nursing Facility) Call Light Policy & Procedure, approved 7/2025, documented resident call lights will be answered in a timely and efficient manner once engaged. The policy documented call lights are answered based on first engaged and urgency of resident need, call lights shall be within reach, and if a resident requires an alternative call light device, the facility will provide (continued on next page)

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	06/24/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	and care plan for the needed device.The facility policy titled, SNF Mechanical Lift Procedure, approved 5/2025, documented the mechanical lift program was intended to promote resident and staff safety during transfers. The procedure required at least two trained staff for all mechanical lift transfers, proper sling placement, secure sling attachments, slow raising/lowering, transfer to the designated surface, removal of the sling if appropriate, and repositioning for comfort and safety.The facility policy titled, Safe Lifting and Movement of Residents, approved 12/2024, documented resident safety, dignity, comfort, and medical condition will be incorporated into decisions regarding safe lifting and moving. The policy documented staff will be trained in mechanical lifting devices, observed for competency, and expected to follow safe lifting procedures.The facility document titled, Certified Nursing Assistant/CNA Job Description, undated, documented CNAs are responsible for assisting residents with daily needs, ADLs (Activities of Daily Living), personal hygiene, answering call lights promptly, keeping residents dry, following care plan approaches, implementing positioning and transfer techniques, and promoting resident rights.

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	06/24/2026

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

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and revise comprehensive, person-centered care plans to include resident-specific problems, goals, and interventions for three (R1, R6, and R12) residents reviewed for comprehensive care plans in the sample of 14. Findings include:1. R1's admission record documented R1 was a [AGE] year-old admitted to the facility on [DATE] from a local hospital with diagnoses including fusion of cervical spine, occipital condyle fracture, chronic pain syndrome, stiffness of the right shoulder and elbow, muscle wasting and atrophy, dysphagia, and lack of coordination.R1's hospital discharge records, dated 5/15/26, documented R1 was discharged from the hospital to the facility after hospitalization related to a motorcycle accident. The records documented multiple traumatic injuries and post-surgical needs, including cervical spinal fusion, multiple fractures, mobility restrictions, braces/splints, anticoagulation therapy, and pain management medications.R1's pain level summary showed ongoing moderate to severe pain, including pain scores of 9 out of 10 on 5/18/26, 7 out of 10 on 5/21/26, 7 out of 10 on 5/22/26, 10 out of 10 on 6/4/26, 9 out of 10 on 6/8/26, and 10 out of 10 on 6/17/26. The pain record showed multi-day gaps without documented pain assessments.R1's vital sign records showed only one documented set of vital signs after admission, completed on 5/15/26. R1's electronic health record did not include additional documented blood pressure, temperature, pulse, respirations, or oxygen saturation monitoring after 5/15/26 through 6/17/26.R1's electronic health record documented R1 was continent of bowel and able to make needs known. R1 required extensive staff assistance due to multiple fractures, non-weight-bearing restrictions, braces, immobility, and pain.R1's current care plan documented orthopedic restrictions, including weight-bearing restrictions and brace/splint instructions; however, R1's care plan did not comprehensively address R1's pain assessment and management needs, vital sign monitoring needs based on condition/skilled status, timely call light response and assistance needs, toileting/continence assistance needs, or safe mechanical lift transfer needs.On 6/23/26 at 11:15 AM, V2/Director of Nursing stated there was nothing in R1's care plan or orders about pain or vital signs. V2 confirmed R1 did not have vital signs documented since admission and had holes of multiple days in pain assessments. V2 stated nurses should complete vital signs and pain assessments with skilled nursing assessment at minimum daily, but mostly every shift, and staff were not completing them.2. R6's admission record documented R6 had medical diagnoses including: chronic obstructive pulmonary disease, hemiplegia affecting the left dominant side, hypertension, muscle wasting and atrophy, chronic pain syndrome, major depressive disorder, alcoholic hepatitis with ascites, atrial fibrillation, heart failure, orthopnea, nicotine dependence, weakness, and other abnormalities of breathing.R6's current care plan documented a focus area for elopement/unit placement, initiated 8/30/24 and revised 5/23/25, which documented R6 will at times sign himself out and go with family or go independently to various places in the community. The goal documented R6 would be safe and secure during his stay. Interventions included R6 was not at risk of leaving home unattended, Social Services would intervene if needed, and wandering/elopement assessments would be completed on admission, quarterly, significant change in condition, and/or as needed.R6's care plan documented a cognition focus area, initiated 9/3/24 and revised 9/24/24, which documented R6 did not always make good decisions as evidenced by leaving the facility and returning with alcohol. The goal documented R6 would make good decisions as able regarding healthy and safe choices when absent from the facility. Interventions included reminding R6 it was not safe to drink while out of the facility, reminding R6 alcohol was prohibited without a physician order, Social Services to intervene as needed, and that R6 had been counseled and reminded he was not to bring alcohol onto the property.R6's care plan also documented R6 was able to participate in therapeutic leave with or without accompaniment. The goal documented R6 would alert staff when he left the (continued on next page)

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	06/24/2026

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

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	building. Interventions included notifying the physician if nursing felt R6 was under the influence and having R6 sign in and out at the nurses' station.3. R12's admission record documented R12 was a [AGE] year-old African American female admitted to the facility on [DATE] from a long-term acute care hospital. R12's medical diagnoses included primary progressive multiple sclerosis, incomplete paraplegia, disorder of muscle, ataxia, cognitive communication deficit, chronic pain, heart failure, and protein-calorie malnutrition.R12's current care plan documented a focus area for YOUNITE Story - Care/ADL (Activities of Daily Living) Preferences, initiated 5/18/26. The goal documented staff would honor R12's preferences while caring for her.R12's care plan further documented a focus area for ADL Self Care Performance Deficit, initiated 5/18/26. The goal documented R12 would maintain her current level of function through the next review date. The care plan documented R12 needed staff assistance with bathing, including set up, supervision, and hands-on assistance with washing and drying. The care plan documented R12 required total assistance with personal hygiene care, was bedfast all or most of the time, was totally dependent on staff for toilet use, and required a mechanical aid for transfers.R12's care plan did not document a focus, goal, or intervention for hair care, grooming assistance related to hair, personal appearance preferences, beautician/barber services, or monitoring/prevention of matted or tangled hair, despite R12's diagnoses and documented need for total assistance with personal hygiene care, staff assistance with bathing, bedfast status, and dependence on staff for ADL care.On 6/23/26 at 10:45 AM, R12 was observed wearing a head covering in her room in bed while V17/Certified Nursing Assistant (CNA) provided incontinence care and bathing. R12's hair was observed to be matted and tangled under the head covering. R12 appeared upset and tearful when discussing her hair. R12 stated no one comes to fix her hair and it gets matted, so she has to wear a covering to hide it. R12 stated she could not braid her own hair because only one hand works.On 6/23/26 at 10:47 AM, V17/Certified Nursing Assistant stated she used to braid R12's hair but was told not to because she was not licensed. V17 stated there was no beautician who comes to the facility to do residents' hair anymore.On 6/23/26 at 11:17 AM, V2/Director of Nursing stated the facility had not been able to find a beautician for years. CNAs are allowed to provide hair care to residents without a license as long as they are not using chemicals or cutting hair.On 6/23/26 at 11:47 AM, V1/Administrator stated the facility did not have a contract with a beautician at that time.R6's care plan did not include current, resident-specific interventions addressing how staff were to monitor, supervise, assess, or intervene when R6 left the facility, returned from the community, or was suspected of returning with alcohol. The care plan did not include clear direction for assessment of intoxication, alcohol possession, notification criteria, staff responsibility, monitoring frequency, safety checks upon return, or interventions related to R6's alcohol-related risk in the context of alcoholic hepatitis with ascites, chronic obstructive pulmonary disease, heart failure, atrial fibrillation, major depressive disorder, chronic pain syndrome, weakness, and hemiplegia.The facility failed to ensure R6's comprehensive care plan was resident-specific and revised to address R6's alcohol-related safety risks, therapeutic leave needs, and monitoring/supervision needs when leaving and returning to the facility.On 6/23/26 at 11:18 AM, V2/Director of Nursing stated each resident should have an individualized care plan that address resident-specific problems and should include a goal and interventions to address each problem identified to ensure residents receive proper care. V2 confirmed care plans were missing important care areas that were resident-specific.The Facility Care Planning Policy, dated 12/2024, documents: purpose to assess each resident's strengths, weaknesses and care needs; use assessment data to develop a comprehensive Plan of Care for each Resident in achieving and maintaining the highest practical level of mental functioning, physical functioning and wellbeing as possible.

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	06/24/2026

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

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 necessary grooming, hair care, personal hygiene, and personal appearance services were provided to maintain the highest practicable physical, mental, and psychosocial well-being for one (R12) resident reviewed for quality of care in a total sample of 14 residents.This deficient practice was evidenced by the facility's failure to provide and/or arrange timely hair care and grooming services for R12, whose hair was observed to be matted. The facility failed to follow its Resident Rights policy and Beautician/Barber policy to ensure R12's grooming and personal appearance needs were met in a manner consistent with R12's preferences, dignity, and quality of life. As a result, R12 experienced embarrassment, distress, and humiliation related to the condition of R12's hair.Findings include:R12's admission record documented R12 is a [AGE] year-old African American female admitted to the facility on [DATE] from a long-term acute care hospital. R12's medical diagnoses included primary progressive multiple sclerosis, incomplete paraplegia, disorder of muscle, ataxia, cognitive communication deficit, chronic pain, heart failure, and protein-calorie malnutrition.R12's current care plan documented a focus area for R12-Care/ADL Preferences, initiated 5/18/26. The goal documented staff would honor R12's preferences while caring for her.R12's care plan further documented a focus area for ADL Self Care Performance Deficit, initiated 5/18/26. The goal documented R12 would maintain her current level of function through the next review date. The care plan documented R12 needed staff assistance with bathing, including set up, supervision, and hands-on assistance with washing and drying. The care plan documented R12 required total assistance with personal hygiene care, was bedfast all or most of the time, was totally dependent on staff for toilet use, and required mechanical aid for transfers.R12's care plan did not document a focus, goal, or intervention for hair care, grooming assistance related to hair, personal appearance preferences, beautician/barber services, or monitoring/prevention of matted or tangled hair, despite R12's diagnoses of primary progressive multiple sclerosis, incomplete paraplegia, disorder of muscle, and ataxia, and despite R12's documented need for total assistance with personal hygiene care, staff assistance with bathing, bedfast status, and dependence on staff for ADLs.On 6/23/26 at 10:45 AM, R12 was observed wearing a head covering in her room in bed while V17/Certified Nursing Assistant was providing incontinence care and bathing. R12's hair was observed to be matted and tangled under the head covering. R12 appeared upset and tearful when discussing her hair. R12 stated, This shouldn't be happening. We shouldn't have to go through this. R12 stated no one comes to fix her hair and it gets matted, so she has to wear a covering to hide it. R12 stated, I don't like my hair like this. I'm embarrassed and don't want to be seen by anyone looking like this. I can't braid my own hair. I only have one hand that works, or I would do it myself.On 6/23/26 at 10:47 AM, V17/Certified Nursing Assistant stated she used to braid R12's hair but was told not to because she was not licensed. V17 stated there is no beautician who comes to the facility to do residents' hair anymore. V17 stated another CNA, V18, is licensed and does residents' hair sometimes, but due to staffing V18 cannot do the residents' hair like it should be done because V18 has to work the floor.On 6/23/26 at 11:17 AM, V2/Director of Nursing stated the facility has not been able to find a beautician for years. V2 stated CNAs are allowed to provide hair care to residents without a license if they are not using chemicals or cutting hair.On 6/23/26 at 11:47 AM, V1/Administrator stated the facility does not have a contract with a beautician at this time. V12/Certified Nursing Assistant helps when she can.The facility failed to ensure R12 received grooming, hair care, personal hygiene, and personal appearance services consistent with R12's assessed needs, preferences, dignity, and quality of life. R12's diagnoses included primary progressive multiple sclerosis, incomplete paraplegia, disorder of muscle, and ataxia. R12's care plan documented R12 required total assistance with personal hygiene, staff assistance with bathing, was bedfast all or most of the time, and required a mechanical aid for transfers. Despite this dependence, (continued on next page)

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	06/24/2026

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

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	the facility failed to ensure staff assisted R12 with routine grooming/hair care or ensured R12 had timely access to beautician/barber services. As a result, R12's hair became matted and tangled, and R12 experienced embarrassment, distress, and humiliation.The facility failed to follow its Resident Rights policies and Beautician/Barber Policy when it failed to provide grooming and personal appearance services consistent with R12's preferences, dignity, and quality of life. The facility also failed to ensure ADL and personal hygiene care was provided to meet R12's needs and maintain R12's highest practicable physical and psychosocial well-being.The facility policy titled, The Resident Rights for People in Long-Term Care Facilities, dated 11/2018, documented residents have the right to make their own choices, be treated with dignity and respect, receive care that promotes quality of life, receive equal access to quality care, receive services to keep physical and mental health at their highest practicable levels, and receive services/items included in the plan of care.The facility policy titled, Facility Resident Rights Policy, dated 12/2024, documented residents have the right to a dignified existence and access to persons and services inside and outside of the community.The facility document titled, Certified Nursing Assistant/CNA Job Description, undated, documented CNAs are responsible for assisting residents with daily needs, ADLs (Activities of Daily Living), personal hygiene, following care plan approaches and promoting resident rights.The facility policy titled, Beautician/Barber Policy, dated 8/2025, documented the facility will ensure residents have access to grooming and personal appearance services consistent with resident preferences, dignity, and quality of life requirements.

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	06/24/2026

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

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 0689 Level of Harm - Minimal harm or potential for 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 finalize a completed fall investigation, document and monitor a head injury and prevent a staff assisted fall and the facility failed to follow its SNF (Skilled Nursing Facility) Mechanical Lift Procedure and Safe Lifting and Movement of Residents policy when staff failed to promptly transfer R1 to the designated surface and reposition R1 for comfort and safety. R1 had multiple fractures, cervical spinal fusion, weight-bearing restrictions, limited upper-extremity use, immobility, and pain. Leaving R1 suspended in the mechanical lift sling while staff switched the beds failed to promote R1's safety, dignity, comfort, and medical condition, and resulted in avoidable pain, fear, discomfort, and distress for two (R1 and R3) residents reviewed for accidents/hazards in a sample of 14.Findings include: 1. R1's admission record documented R1 was a [AGE] year-old admitted to the facility on [DATE] from a local hospital with diagnoses including fusion of cervical spine, occipital condyle fracture, chronic pain syndrome, stiffness of the right shoulder and elbow, muscle wasting and atrophy, dysphagia, and lack of coordination. R1's hospital discharge records, dated 5/15/26, documented R1 was discharged from a local hospital to the facility on 5/15/26 after hospitalization from 4/10/26 to 5/15/26 related to a motorcycle accident. The records documented multiple traumatic injuries and post-surgical needs, including cervical spinal fusion, multiple fractures, mobility restrictions, braces/splints to extremities, anticoagulation therapy, and pain management medications. R1's nursing progress note, backdated to 5/15/26 at 10:35 AM, documented R1 arrived via ambulance with a family member, was alert and able to make needs known, and had multiple fractures including acetabulum, wrist, and skull fractures. The note documented R1 was non-weight bearing to the right upper extremity, left upper extremity, and right lower extremity, and weight bearing as tolerated to the left lower extremity for transfers only. R1's Social Service note, dated 5/15/26 at 2:42 PM, documented R1 was admitted from a local hospital after a motorcycle accident, was currently unable to use his arms, and was independent with decision making. On 6/17/26 at 11:40 AM, R1 was observed in his room awake, alert, and able to make his needs known. R1 stated he arrived at the facility on 5/15/26 around 10:00 AM. R1 stated no one came to his room until a few hours later. R1 stated when he later switched rooms, the beds in the new room had to be switched because they were not functioning. R1 stated staff transferred him from his wheelchair with a mechanical lift and sling before realizing the beds needed to be switched. R1 stated he was left suspended in the mechanical lift sling for approximately 15 minutes while staff switched the beds. R1 stated no staff members were present while he was suspended in the mechanical lift sling. On 6/18/26 at 12:24 PM, V15/R1's Family Friend stated she followed R1 in the ambulance to the facility on 5/15/26 and stayed with him from approximately 10:00 AM until 6:00 PM because she did not want to leave R1 at the facility after the day unfolded. V15 stated R1 sat in the initial room until approximately 2:00 PM without seeing anyone. V15 stated R1 did not want to stay after the first four hours, and they called the non-emergency line to transfer R1 to a different facility. V15 stated, I was (continued on next page)

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	06/24/2026

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	crying it was so bad. V15 stated two staff came in and offered to move R1 to a new room, and R1 was left suspended in the mechanical lift sling for about 15 minutes while staff switched out beds in the new room. V15 stated one bed was a crank bed, and the other bed did not work. V15 stated R1 complained his neck hurt and he was in obvious pain while in the lift. V15 stated R1 did not receive medications, including pain medication, no vitals were completed, and no nursing assessment was performed while she was present from approximately 10:00 AM until 6:00 PM. On 6/18/26 at 11:28 AM, V14/R1's Family Member stated R1 and V15 told her R1 was left in the air in a sling for approximately 15 minutes during transfer from the wheelchair to the bed while staff switched the beds. V14 stated R1's legs were going numb, R1 was in pain, and R1 was yelling out for help with no one around. On 6/18/26 at 12:35 PM, V2/Director of Nursing stated CNAs should not leave a resident suspended in a mechanical lift sling unattended or for prolonged periods of time. V2 stated she would expect staff to transfer the resident back to the chair and not leave the resident in the mechanical lift. The Facility Skilled Fall Policy, dated 5/2025, documents: the purpose is to develop, implement, observe and evaluate an interdisciplinary approach and manage strategies and interventions that foster resident independence and quality of life; promotes safety, prevention and education of both staff and residents; each resident will be provided services and care that ensures 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; each resident who experiences a fall will be treated and assessed to adequately treat any current injuries and comprehensively assessed to determine casual effects; and after each fall, the occurrence report will be completed, root cause will be determined and interventions implemented. The Facility Post Fall Workflow Policy, dated 5/2025, documents: steps to be taken will include the residents provider and representative must be notified of the resident's fall; an occurrence report must be completed and reviewed by nursing administration for completeness in the next daily meeting; nursing administration will investigate and conclude each, document root cause, record witness statements and finalize the occurrence report; a progress note must be documented in the resident's record, including root cause analysis, resident representative notification, details of injury, pertinent statements and other details surrounding the resident's fall; and post fall documentation must be done every shift for 72 hours following the fall. The Facility Fall Analysis Log, dated 3/2026, documents a fall for R3 on 3/26/26 at 8:00 am, in R3's room. The Log documents R3 tipped over backwards in wheelchair, had no injury and was hospitalized . The new intervention was anti-tip backs on R3's wheelchair. 2.R3's Physician Order Sheet, dated 6/18/26, documents R3 admitted to the facility on [DATE], with diagnoses including Epilepsy, Seizures, Depressive Disorder, Left Foot Drop, Right Foot Drop, Panic Disorder, Lumbar Region Radiculopathy and Wedge Compression Fracture of T11-T12 Vertebra. V9 (Registered Nurse/RN) completed R3's Fall Investigation Report, dated 3/26/26 at 8:00 am, documents resident wheelchair laying on its back with resident (R3) in it. Resident did hit head on floor. The Fall Report documents R3 has bump on back of head and also documents no injury observed. The Fall Report is not entirely completed and does not document mental status, injury description (size and location), pain level, predisposing environmental factors or predisposing situation factors. The Fall Report documents V24 (R3's Sister/Power of Attorney) was notified on (continued on next page)

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	06/24/2026

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/26/26 at 8:30 am. The Fall Report does not document witnesses/staff present interviews, monitoring of a description of size, color or location of R3's head injury/bump. R3's Fall Investigation Reports document previous falls on 1/21/26, 1/31/26, 2/2/26 and 2/20/26. R3's Nursing Progress Note, dated 3/26/26 at 9:59 am, documents R3 had a change in condition and is currently experiencing is fall struck head. R3's Nursing Progress Note, dated 3/26/26 at 10:17 am, documents (R3's) wheelchair tipped over while staff was trying to get clothing unwrapped from wheelchair wheel. (R3) hit head on the floor and that (R3) complained of increased pain to the head after (pain medication) was given. R3's Nursing Progress Note, dated 3/26/26 at 12:38 pm, documents at Emergency Room/ER. R3's late entry Nursing Progress Note, dated 3/26/26 at 4:30 pm, documents resident returned from the ER. R3's Nursing Progress Notes, dated 3/26/26 through 3/30/26, do not document monitoring of a description of size, color or location of R3's head injury, or witnesses/staff present interviews R3's current Care Plan documents R3 is at risk for falls and documents interventions for falls. On 6/18/26 at 10:45 am, V9 (Registered Nurse/RN) stated, I was the nurse on duty when (R3) fell on 3/26/26, but I do not remember which CNA's (Certified Nursing Assistants) were here, and I did not document their names on anything in the medical record. (R3) was in the middle of the hallway and (R3's) clothing got caught in (R3's) wheelchair wheels. When the CNAs were helping (R3), the wheelchair tipped backwards and (R3) hit her head on the floor. I did not document any description of the bump on (R3's) head but I do think, if I remember correctly, (R3) had a bump on the back left side of head. (R3) was complaining of pain and we sent (R3) to the hospital emergency department. I do not remember if I called and notified (V24/R3's Sister) or not. On 6/17/26 at 8:51 am, V24 (R3's Sister/Power of Attorney) stated, I found out from my sister (R3), that they tipped her out of her wheelchair and hit her head. No one ever notified me, my sister (R3) told me later. On 6/18/26 at 11:05 am, V2 (Director of Nursing) stated, The nurses are responsible for entirely completing the fall investigations when a fall occurs. They should include a description of injuries and any witnesses present. I do not see that the staff that were helping (R3) with the clothing that was stuck in the wheelchair wheel were identified. I also do not see that any description or monitoring of measurements, size or exact place of (R3's) head injury was documented. The facility policy titled, SNF Mechanical Lift Procedure, approved 5/2025, documented the mechanical lift program was intended to promote resident and staff safety during transfers. The procedure required at least two trained staff for all mechanical lift transfers, proper sling placement, secure sling attachments, slow raising/lowering, transfer to the designated surface, removal of the sling if appropriate, and repositioning for comfort and safety. The facility policy titled, Safe Lifting and Movement of Residents, approved 12/2024, documented resident safety, dignity, comfort, and medical condition will be incorporated into decisions regarding (continued on next page)

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	06/24/2026

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	safe lifting and moving. The policy documented staff will be trained in mechanical lifting devices, observed for competency, and expected to follow safe lifting procedures.

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	06/24/2026

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

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide necessary pain assessment, monitoring, and intervention to maintain the highest practicable physical and psychosocial well-being for one (R1) resident reviewed for pain management, in a total sample of 14 residents. This failure to assess and intervene when R1 was reported to be in pain during care and transfers, including when R1 was left suspended in a mechanical lift sling while beds were switched and when R1 waited an extended period in a wheelchair after activating the call light and requesting to return to bed due to pain. This failure resulted in R1 experiencing prolonged, unassessed, and/or unmanaged moderate-to-severe pain.Findings include:R1's admission record documented R1 was a [AGE] year-old admitted to the facility on [DATE] from a local hospital with diagnoses including fusion of cervical spine, occipital condyle fracture, chronic pain syndrome, stiffness of the right shoulder and elbow, muscle wasting and atrophy, dysphagia, and lack of coordination.R1's hospital discharge records, dated 5/15/26, documented R1 was discharged from a local hospital to the facility on 5/15/26 after hospitalization from 4/10/26 to 5/15/26 related to a motorcycle accident. The records documented multiple traumatic injuries and post-surgical needs, including cervical spinal fusion, multiple fractures, mobility restrictions, braces/splints to extremities, anticoagulation therapy, and pain management medications.R1's nursing progress note, back-dated to 5/15/26 at 10:35 AM, documented R1 arrived via ambulance with a family member, was alert and able to make needs known, and had multiple fractures including acetabulum, wrist, and skull fractures. The note documented R1 was non-weight bearing to the right upper extremity, left upper extremity, and right lower extremity, and weight bearing as tolerated to the left lower extremity for transfers only.R1's Social Service note, dated 5/15/26 at 2:42 PM, documented R1 was admitted from a local hospital after a motorcycle accident, was currently unable to use his arms, and was independent with decision making.R1's nursing progress note, dated 5/18/26 at 11:39 AM, showed V2/DON documented R1's mother reported R1 had his call light on for 40 minutes and was in pain wanting to be put back in bed. The note documented the CNA was waiting for someone from another hall to assist with transferring R1 back to bed. The record did not show an assessment of R1's pain level at that time, did not show documentation of an intervention to relieve R1's pain, and did not show documentation that R1 was timely assisted back to bed.On 6/17/26 at 11:40 AM, R1 stated that approximately three days after admission, on 5/18/26, he was in his wheelchair in pain and wanted to go back to bed. R1 stated he pressed the call light with no response, attempted to call the facility's phone number with no answer, and then called V14/R1's Family Member for assistance.On 6/18/26 at 11:28 AM, V14 stated she received a phone call from R1 on 5/18/26. V14 stated R1 told her his call light had been on while he was left in his wheelchair in pain and no one answered the call light for over an hour. V14 stated R1 then attempted to call the facility and could not get through, so he called her. V14 stated this was one of R1's first times up in the chair after the wreck, injuries, and hospitalization, so she was concerned for his safety because she was three hours away. V14 stated she called the facility and spoke with V2/DON. V14 stated V2 told her R1 would have to wait because he required two people to transfer and one CNA on the hall was on break.On 6/18/26 at 11:28 AM, V14/R1's Family Member stated R1 and V15 told her R1 was left in the air in a sling for approximately 15 minutes during transfer from the wheelchair to the bed while staff switched the beds. V14 stated R1's legs were going numb, R1 was in pain, and R1 was yelling out for help with no one around.On 6/18/26 at 12:24 PM, V15/R1's Family Friend stated V15 stated two staff came in and offered to move R1 to a new room, and R1 was left suspended in the mechanical lift sling for about 15 minutes while staff switched out beds in the new room. V15 stated one bed was a crank bed and the other bed did not work. V15 stated R1 complained his neck hurt and he was in obvious pain while in the lift. V15 stated R1 did not receive medications, including pain medication, no vitals were completed, and no nursing assessment was performed while she was (continued on next page)

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	06/24/2026

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

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 0697 Level of Harm - Actual harm Residents Affected - Few	present from approximately 10:00 AM until 6:00 PM.On 6/18/26 at 12:35 PM, V2/DON stated she did tell V14 that R1 was going to have to wait. V2 stated she did not offer to go down and told the nurse and CNA taking care of R1 that shift. V2 stated, I assumed they would take care of it.On 6/18/26 at 2:20 PM, V3/Licensed Practical Nurse stated she worked second shift on 5/15/26 and completed R1's admission assessment after 6:00 PM to help her coworker. V3 stated there was a lot of passing on between nurses related to the admission and that was another reason the assessment was completed late. V3 stated, The assessment should have been completed sooner, but we were busy.On 6/18/26 at 2:30 PM, V9/Registered Nurse stated she was the nurse assigned to R1's original room assignment hall on 5/15/26 and received report from the hospital. V9 stated she did not assess R1 because she was busy entering medication orders. V9 stated, I did not do any vital signs or assessments on R1 when he got here. I only put a note in stating that he arrived at the building.R1's current physician order summary, dated 6/17/26, did not include orders to monitor vital signs or pain level.On 6/23/26 at 10:35 AM, V9/Registered Nurse, V22/Licensed Practical Nurse, and V23/Licensed Practical Nurse stated all residents should have a pain assessment completed every shift and residents receiving skilled nursing care should have vital signs completed every shift. V9, V22, and V23 confirmed R1 did not have orders for vital signs or pain assessments and confirmed R1 had no vital signs entered since 5/15/26 and had multiple occasions with several days between pain assessments.On 6/23/26 at 11:15 AM, V2/Director of Nursing stated there was nothing in R1's care plan or orders about pain or vital signs. V2 confirmed R1 did not have vital signs documented since admission and had holes of multiple days in pain assessments. V2 stated nurses should complete vitals and pain assessments with skilled nursing assessment at minimum daily, but mostly every shift, and they were not completing them.R1's physician order summary showed orders for hydrocodone-acetaminophen, oxycodone, acetaminophen, methocarbamol, non-weight-bearing status, brace/splint use, passive range of motion, therapy, and CPM (Continuous Passive Motion) machine use.R1's pain level summary showed R1 had ongoing moderate to severe pain, including pain scores of 9/10 on 5/18/26, 7/10 on 5/21/26, 7/10 on 5/22/26, 10/10 on 6/4/26, 9/10 on 6/8/26, and 10/10 on 6/17/26. The pain record showed multi-day gaps without documented pain assessments, including gaps from 5/18/26 to 5/21/26, 5/22/26 to 5/29/26, 5/29/26 to 6/4/26, and 6/12/26 to 6/17/26.The facility failed to follow its Pain Management policy, which required pain assessments at least every shift, when R1 had multi-day gaps without documented pain assessments despite repeated moderate to severe pain, multiple traumatic injuries, cervical spinal fusion, chronic pain syndrome, immobility, and prescribed pain medications.R1's daily skilled nursing notes dated 5/17/26, 5/18/26, 5/19/26, 5/20/26, 5/21/26, 5/31/26, 6/2/26, 6/5/26, and 6/10/26 documented R1 required skilled services including nursing observation and assessment, management of the care plan, therapy, medication management, and/or teaching and training. The notes identified the reason for skilled services as motor vehicle accident, multiple fractures, immobility, pain, therapy, and/or wound care.The facility policy titled, Pain Management, dated 2/2025, documented each resident has the right to optimal pain assessment and management. The policy documented unrelieved pain can have adverse psychological and physiological effects, and pain management enhances healing and promotes physical and psychological wellness. The policy documented pain assessments were to be completed at least every shift.

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	06/24/2026

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

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation, interview and record review the Facility failed to maintain environmental equipment safety, comfortability and appearance for a torn/ripped bed mattress that created unsafe gaps for one resident (R10) reviewed for environment in a sample of 14.Findings include:On 6/18/26 at 8:11 am, R10 was sitting in a wheelchair in R10's room and R10's bed was unmade (no sheets/blankets/bedspread). An exposed blue mattress had a moderate amount of brown/tan punctures on the outer layer that exposed the internal mattress materials and exposed dips/lumps were noted on the sleeping surface. R10 stated, Oh, they know about it, I have been telling them about this mattress for over a year. It looks terrible and is very uncomfortable. I do not know why they do not notice it when they change my bedding.On 6/18/26 at 8:06 am, V7 (Housekeeping Supervisor) stated, Staff are real good about letting me know about mattresses that need to be changed out. They tell me if they see a dirty or worn mattress, so we can swap it out.On 6/18/26 at 8:35 am, V7 (Housekeeping Supervisor) entered R10's room, and exchanged R10's mattress. V7 stated, I overheard you talking to (R10), so I just took it upon myself to change the mattress.On 6/25/26 at 10:00 am, V1 (Administrator) stated, I have been ordering new mattresses, I am not sure how they missed that one. The nursing staff, housekeeping staff and maintenance all usually work together when they see a mattress that needs changed.The Resident Rights for People in Long-Term Care Facilities, dated 11/2018, documents: right to make own choices; must treat you with dignity and respect and care for you in a manner that promotes quality of life; must provide equal access to quality care regardless of diagnoses or condition; must provide services to keep physical and mental health at their highest practical levels; and should be provided services and/or items included in plan of care.The Facility Resident Rights Policy, dated 12/2024, documents residents have the right to a dignified existence.The Certified Nursing Assistant/CNA Job Description, undated documents: responsible for delivering and assisting residents with daily needs; to provide activities of daily living; responsible for knowledge of proper procedures to provide personal care services; prepares equipment; serves and protects by adhering to professional standards, company policies and procedures, federal, state and local requirements; and understands, upholds and promotes the rights of the residents.