

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145440	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2025
NAME OF PROVIDER OR SUPPLIER Neighbors Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 811 West 2nd Byron, IL 61010	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on interview and record review the facility failed to ensure residents were treated in a dignified manner. This applies to 1 of 41 residents (R33) reviewed for dignity in the sample of 41.</p> <p>The findings include:</p> <p>On May 19, 2025, at 1:10 PM, V14 (Licensed Practical Nurse/LPN) stated, her, V9 (LPN) and V12 (Dietary Manager) got into a verbal altercation at the nurses' station. V9 and her work the night shift. They were giving report to the oncoming day shift when V12 (Dietary Manager) overheard them talking about their concerns with the dinner meal the night before. He was calling us wussies and telling us that the menu is planned out by a dietitian. V14 admitted to calling the dietitian a dumb b****. Another staff member (V22 Certified Nursing Assistant/CNA) saw what was happening and told her to stop and leave it alone. She admitted to saying 2 cuss words. R33 was up and sitting by the nurses' station.</p> <p>On May 19, 2025, at 1:43 PM, V22 (CNA) stated, V12 (Dietary Manager), V9 (LPN) and V14 (LPN) were arguing at shift change. V12 was punching in the time clock (which is right by the nurses' station) and overheard V9 and V14 were upset about the dinner the night before and residents were hungry. He got defensive and very aggressive verbally. He was saying the dietitian makes the menu and they follow the menu. V14 did swear and called her a stupid b****. I told V14 to walk away but she was mad. R33 was sitting by the nurses' station.</p> <p>On May 19, 2025, at 2:43 PM, V12 (Dietary Manager) stated, he got to work around 6:00 AM and heard the nurses talking about what was served for dinner the night before. I tried to let them know the menus are approved and sent to us through a dietitian. V14 (LPN) stated, the dietitian was a stupid b****. I was trying to talk with V9 (LPN) and V14 kept intervening our conversation. Even V22 (CNA) told her to stop the conversation was inappropriate. V14 stated, she didn't give a f***. He wasn't sure who exactly was sitting out by the nurses' station at the time of the argument, but it was 1 or 2 residents that were there.</p> <p>On May 20, 2025, at 10:58 AM, V10 (LPN) stated, she witnessed the argument with V9 (LPN), V14 (LPN) and V12 (Dietary Manager). It was awful. V12 (Dietary Manager) was instigating that. R33 was sitting up by the nurses' station. She is always up there.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's resident privacy and dignity policy dated October 2021 shows, Objective: This policy is intended to set out the values, principles and policies underpinning the facility approach to privacy and dignity Procedure: 2. Staff should remember the following: g) Never discuss private or personal issues with a resident in public, h) Avoid the use of patronizing or insulting language.</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to keep a resident free from physical abuse. This applies to 4 of 6 residents (R1, R2, R3 & R4) reviewed for abuse in the sample of 41. This failure resulted in R1 being sent to the local hospital and diagnosed with a posterior head laceration and initial CTH with acute SDH (computed tomography with acute subdural hematoma) of the left frontal, parietal, and temporal lobes.</p> <p>The findings include:</p> <p>1. The facility's final report to the state surveying agency regional office dated December 20, 2023, shows, It was immediately reported to Administrator (V1) that R1 sustained a fall with injury while in the memory care dining room. Staff reported that they heard a female resident say that a resident is moving the chair around and to leave it alone, when the one CNA (Certified Nursing Assistant) turned toward the resident she saw R1 and another male resident (R2) both had hold of the chair and due to the momentum of both residents tugging at the chair they both fell. R2 the other male resident landed on top of R1 which caused him to hit his head on the corner of the wall Conclusion: Based on a thorough investigation resident (R1) sustained a laceration to the back of his [head] requiring staples and had a small subarachnoid hematoma requiring no surgical interventions as a result of two dementia residents wanting to move the same chair around the table, they lost their balance and fell together</p> <p>On May 14, 2025, at 1:58 PM, V11 (CNA) stated, she witnessed the incident between R1 and R2 on December 20, 2023. She was in the dining room helping another resident with her back turned towards R1 and R2. R1 was sitting at a table in the dining room. R2 was up walking around. She heard R12 (another female resident) screaming, They are going to fight. They are going to fight. so she turned around to see R1 and R2. R1 was trying to stand up from the table as R2 had a chair and was shoving the chair towards R1. She tried to grab the chair but was not able too. R2 shoved the whole chair into R1 hitting him and causing him to fall back and hit his head on the corner of the wall. R1 hit the wall so hard there was pieces of plaster/dry wall on the floor. He was also bleeding badly.</p> <p>On May 15, 2025, at 8:03 AM, V3 (CNA) stated, R1 and R2 were fighting. R2 hit R1 and caused R1 to fall backward and hit his head hard on the wall. R2 was in an aggressive mood and wanted to still fight R1. R2 would get aggressive with staff but never the other residents. This was the first time he hit a resident that she knew of.</p> <p>R1's local hospital paperwork dated December 31, 2023, shows, History and Physical: .R1 was admitted to local hospital on [DATE] after a fall at his nursing home, he had an argument with another NH (nursing home) resident who pushed him backward against a wall and struck his head. He had a posterior head laceration and initial CTH with acute SDH (computed tomography with acute subdural hematoma) of the left frontal, parietal, and temporal lobes .</p> <p>R1's progress notes dated December 20, 2023, shows, The resident fell in the common area during breakfast and hit the back of his head on the corner of the wall. Bleeding was noted</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R2's progress notes dated December 20, 2023, shows, Resident fell in the common area during breakfast as a result of pushing a chair. Resident has no injury and was able to stand up by himself .</p> <p>2. R3's progress notes written by V9 (Licensed Practical Nurse/LPN) dated December 7, 2023, shows, Resident had a disagreement with his roommate that had escalated between them. Decision was made to separate the roommates per both of their requests.</p> <p>On May 15, 2025, at 8:33 AM, V9 (LPN) stated, the incident with R3 and R4 happened in the middle of her shift, December 2023. R3 and R4 got into a fight. R3 and R4 both got up and were arguing. R3 tried to walk over to R4 and fell. R4 started kicking him. She broke them apart and separated them. V8 (CNA) was there also. She moved R3 into another room and called V1 (Administrator). She stated, V1 (Administrator) told her how to document the incident.</p> <p>On May 14, 2025, at 12:57 PM, V8 (CNA) stated, she heard commotion and went to R3 and R4's room. When she walked in R4 was kicking R3 pretty badly. She yelled for V9 (LPN). V9 came down and together they got them separated.</p> <p>R3's progress notes written by V1 (Administrator) dated December 8, 2023, shows, Administrator followed up with resident regarding his disagreement with his roommate. Resident explained that they were having a disagreement about the television being loud and when this resident went to get up to try to turn his roommate's television down, he said, my chair got away from me and I sat on the floor. He states that his roommate then laughed at him because he sat on the floor. Staff heard this resident asking for help and they assisted the resident back into his chair</p> <p>R3's progress notes written by V7 (Nurse Practitioner/NP) dated December 12, 2023, shows, CC (current concern): bruising, recent fall. HPI (history of presenting illness): Patient is reporting that on 12/7 he was pushing his wheelchair and it got away from him. He fell landing on his buttocks. He goes on to report that while he was on the floor, his roommate kicked me. He points to bruises to his right upper arm and elbow and the top of his head. He previously has denied any physical contact was made .Bruising noted to right hip and along right gluteal fold. Tenderness with palpation to right hip and low back. Right upper arm with resolving bruise and bruising noted at right elbow. Tender with palpation. Elbow with full ROM (range of motion). No BLE (bilateral lower extremity) edema. IMPRESSION/PLAN: 1. S/P Fall: x-ray right humerus, elbow, hip, pelvis, and lumbar/sacral spine. 2. Contusions: due to being on Brillinta and ASA increased bruising is expected and appears to be resolving. 3. Head contusion: denies LOC. No h/a. Resolving bruising.</p> <p>On May 14, 2025, at 12:16 PM, V6 (LPN) stated, R3 and R4 never really got along. She wasn't the nurse when they got into a fight in their room however she was the nurse a few days later. It was reported to her that R3 had some bruises on him. She asked him what the bruises were from. R3 told her that he had a fall and when he was on the ground R4 was kicking him. She reported that information to V1 (Administrator) and V7 (NP). R3 was alert and oriented x3. V7 ordered x-rays and when the x-rays came back R3 had a fracture on his lower spine.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On May 14, 2025, at 12:28 PM, V7 (NP) stated, these two guys (R3 & R4) were rowdy guys. She was asked to see R3 because he had some bruising, and no one knew where it was from. She assessed R3 and thought his bruises were of a defensive nature. He had bruising on the back of his arms and covering his head. R3 told her his wheelchair got away from him and he fell on the floor. He was on R4's side of the room and R4 started kicking him. His statement was supportive with the bruising she assessed. R3 was not happy she put her documentation in of what she saw on R3.</p> <p>On May 19, 2025, at 12:01 PM, R4 stated, he remembered R3. R3 was threatening to kick his a**. He told him, No you won't. R3 came at him, and he knocked him down and started kicking him. I warned him.</p> <p>R4's electronic medical record does not show, any documented incidents with R3.</p> <p>The facility's final report to the state surveying agency regional office dated August 19, 2024 shows, Administrator received an anonymous call today reporting that some time back in December 2023 the two residents (R3 & R4) had a disagreement in their room and R4 made physical contact with R3. R3 no longer resides in the nursing home, he was discharged as of 6/6/2024. The caller refused to provide any additional information. Local police department was notified, and they provided a case number but because it was an anonymous call and no claim from the victim, they will not be investigating .</p> <p>R4's Minimum Data Set, dated [DATE], shows, he is cognitively intact.</p> <p>The facility's abuse prevention guidance dated October 2022 shows, Policy Statement: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this guidance is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents Definitions: The following definitions are based on federal and state laws, regulations and interpretive guidelines. Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means (210 ILCS 45/1-103). Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident (42 CFR 483.5)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review the failed to ensure an allegation of abuse was reported to the state surveying agency in a timely manner. This applies to 2 of 6 residents (R3 & R4) reviewed for abuse in sample of 41.</p> <p>The findings include:</p> <p>On May 15, 2025, at 8:33 AM, V9 (Licensed Practical Nurse/LPN) stated, R3 & R4 got into a fight in their room, December 2023.</p> <p>R3's progress notes dated December 7, 2023, shows, Resident had a disagreement with his roommate that had escalated between them. Decision was made to separate the roommates per both of their requests.</p> <p>On May 19, 2025, at 12:01 PM, R4 stated, he remembered R3. R3 was threatening to kick his a**. He told him, No you won't. R3 came at him, and he knocked him down and started kicking him. I warned him.</p> <p>The facility did not report the incident to state surveying agency or local police department at the time of the incident.</p> <p>R3's progress notes written by V7 (Nurse Practitioner/NP) dated December 12, 2023, shows, CC (current concern): bruising, recent fall. HPI (history of presenting illness): Patient is reporting that on 12/7 he was pushing his wheelchair and it got away from him. He fell landing on his buttocks. He goes on to report that while he was on the floor, his roommate kicked me. He points to bruises to his right upper arm and elbow and the top of his head. He previously has denied any physical contact was made</p> <p>The facility did not report the incident following allegations made to V7 (NP) on December 12, 2023.</p> <p>The facility's final report to the state surveying agency regional office dated August 19, 2024 (8 months after the initial incident) shows, Administrator received an anonymous call today reporting that some time back in December 2023 the two residents (R3 & R4) had a disagreement in their room and R4 made physical contact with R3. R3 no longer resides in the nursing home, he was discharged as of 6/6/2024. The caller refused to provide any additional information. Local police department was notified, and they provided a case number but because it was an anonymous call and no claim from the victim, they will not be investigating .</p> <p>On May 14, 2025, at 11:27 AM, V1 (Administrator) stated, corporate received an anonymous phone call through their compliance hotline stating that two gentlemen back in December 2023 (R3 and R4). At the time of the initial incident, it was instantly determined that both gentlemen had no contact so she never reported the incident. When the anonymous call came in, then she reported it. She stated, she had a soft file but never provided anything other than the original report sent into the state surveying agency on August 19, 2024 (8 months after initial incident).</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's abuse prevention guidance dated October 2022 shows, Policy Statement: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this guidance is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents Procedures: V. Internal Reporting Requirements and Identification of Allegations: .Supervisors shall immediately inform the administrator or person designated to act in the administrator's absence of all reports of incidents, allegations or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property. Upon learning of the report, the administrator or a designee shall initiate an incident investigation. Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately, but not more than two hours of the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review the facility failed to assess and treat a resident after the resident hit their head when their wheelchair flipped backwards. This applies to 1 of 3 residents (R34) reviewed for quality of care in the sample of 41.</p> <p>The findings include:</p> <p>On May 20, 2025, at 11:17 AM, V34 (R34's daughter) stated, R34 had appointment at his orthopedic office. The facility transported R34 to the appointment and she met him there. She noticed a scrape on the crown of his head. R34 told her that the guy flipped him over on the way to the appointment. He stopped too fast and flipped him backwards and his head got scraped. She called the facility and asked what was going on. They said they got over booked and the maintenance man (V19) had to drive him to the appointment. The facility was going to have a nurse that previously worked in the neurology department at the hospital look at him. They checked him out and he was fine just had a scrape on the top of his head that was all she knew.</p> <p>On May 20, 2025, at 11:57 AM, R34 stated, he remembers the guy flipping him backwards in the van on the way to his appointment. I'm fine.</p> <p>On May 20, 2025, at 11:33 AM, V19 (former Maintenance Director) stated, he transported R34 to his appointment on April 15, 2025. He made sure he was strapped down and buckled in. He was at a stop light and when he went to go forward, R34's wheelchair fell backwards. He pulled over right away and picked him up. R34 told him he was fine. He has done a million of these transports and has never had any issues. This was the first time. He continued taking R34 to his appointment and waited for him until he was done. He did not call the facility and let them know because R34 said he was fine, and he was at the doctor's office. I didn't know, I'm just the maintenance guy just trying to get him to his appointment.</p> <p>On May 20, 2025, at 11:07 AM, V33 (Registered Nurse/RN) stated, R34 had an appointment and V19 (former Maintenance Director) took him to his appointment. Someone (she couldn't remember who) approached her and asked if she had heard what happened to R34 on the way to his appointment. Supposedly, R34's daughter (V34) called and was irate because she wasn't informed that her dad had an incident on the transport van. He flew backwards and hit his head. A little while later, V2 acting Director of Nursing/Assistant Director of Nursing (DON/ADON) was pushing R34 down the hall. She got R34 situated in the room and told V33 (RN) that she assessed him, and he was ok. She didn't need to worry about charting but to start doing neuro checks on him every hour. She stated, she got busy because she had 8 nursing students and did not do any neuro checks. She only did hourly charting (which was not in R34's electronic medical record). The incident happened on April 15, 2025. She did not call anyone and inform them of R34's incident.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On May 20, 2025, at 12:13 PM, V2 (acting DON/ADON) stated, her understanding was that V34 (R34's daughter) called and said, R34 fell in the transport van on the way to his appointment. She was asked to check out R34 when he got back from his appointment. Once he returned, she took him to his room and assessed him. She used to work as an ICU (Intensive Care Unit) RN with a specialty in neurology trauma. She thought R34 was fine. She did not chart what she assessed, neuro checks or notified any physician about R34 falling backwards and hitting his head. She told V33 (RN) to do hourly neurology checks on him. She stated, doing neurology checks on someone after they hit their head would help determine if something is wrong. The facility's policy is to do neuro checks and document the incident. She also confirmed she is a Registered Nurse and not a Nurse Practitioner (NP) or Physician.</p> <p>On May 20, 2025, at 11:58 AM, V7 (NP) stated, she was not notified of R34's incident in the transport van. V2 (acting DON/ADON) checked him and said he was fine.</p> <p>R34's electronic medical record does not show any incidents have happened related to a fall in the transport van on the way to a follow up appointment with his orthopedic physician. There is no documentation related to R34's incident (progress notes, neuro checks, incident report, notification of physician).</p> <p>The facility's fall prevention and management dated December 2023 shows, Purpose: .Additionally, the program addresses a safe process to follow for supporting a resident who has experienced a fall event Documentation: In the medical record, document the vent, outcome, and initial and ongoing observations, and update fall risk assessment and care plan. Documentation includes notification of licensed independent practitioner and resident's representative.</p> <p>The facility's medical emergencies policy (no date) shows, 5. If head injury has occurred and resident is unable to communicate their physical status, notify physician for orders for immediate transport to the emergency room for further evaluation. If resident has the ability to communicate and assessment finds no abnormalities in neurological status and there are no visible signs of significant injury, monitor vital signs and neuro checks at least every four (4) hours for twenty- hour [four]24 hours, or until stable, or as otherwise ordered by physician.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were transferred in safe manner with properly working equipment for 3 of 41 residents (R8, R36, R40) reviewed for safety in the sample of 41.</p> <p>The findings include:</p> <p>1. On [DATE] at 9:55 AM, V22 (Certified Nursing Assistant/CNA) said on [DATE] she was toileting R36 using the sit to stand machine. V22 said she had R36 standing up with her arms above her head attached to the machine with the sling when she attempted to lower R36 to the toilet. V22 said the battery died and the machine wouldn't lower R36. V22 said she got other batteries and none of the batteries she tried were working. V22 said R36 was getting weak and starting to panic, so she tried to use the emergency release on the machine, and it wouldn't release. V22 said she had to put her knees under R36's bottom, and with a gait belt around R36's waist, manually lower R36 to the wheelchair. V22 showed this surveyor a mechanical lift in the resident hallway and pointed out the red emergency release ring was not connected to the shaft and slid up and down with no effect. V22 said this is broken, the emergency release should be connected to the shaft. V22 said they didn't have reliable equipment and staff have let the management know. V22 did not put a broken sign on the machine or remove the machine from the hallway.</p> <p>On [DATE] at 9:37 AM, V38 (CNA) said R36 is a mechanical lift. V38 said R36 has bad arthritis and pain in her knees and has dementia and doesn't know how to use the sit to stand machine.</p> <p>On [DATE] at 10:55 AM, V37 and V38 (CNAs) transferred R36 from her wheelchair to the bed. V38 said, while transferring R36, the emergency release doesn't work on this machine, they had just tried to use it on R8 (R36's roommate). V38 attempted to use the emergency release on the lift to show this surveyor and the release did not release. V37 and V38 continued transferring R36 to bed, provided incontinence care and then transferred R36 back to her wheelchair. V37 and V38 then transferred R8 from her bed to her wheelchair with the same mechanical lift machine.</p> <p>On [DATE] at 11:45 AM, V15 (Restorative Nurse) said she was notified that staff was doing a sit to stand transfer on R36 and the equipment malfunctioned. V15 said she told staff to always use a mechanical lift for R36. V15 said R36 is supposed to be a mechanical lift, but the girls were doing a trial with R36 on a sit to stand machine. V15 said she did not do an assessment on R36 to change R36's transfer status from a mechanical lift to a sit to stand. V15 said R36's cognition has been on the decline, and she is not appropriate for the sit to stand based on that.</p> <p>R36's Care Plan dated [DATE] shows R36 is at risk for activities of daily living decline related to generalized weakness and transfers via mechanical lift. Resident has inability to transfer self. Resident is a mechanical lift. Resident has impaired cognitive function/dementia or impaired thought processes i.e , memory/recall; orientation; decision making; delusional though content; etc., related to Alzheimer's, Dementia.</p> <p>2. On [DATE] at 10:35 AM, V22 and V39 (CNAs) transferred R40 from the bed to his wheelchair using the same mechanical lift with the unattached emergency release lever.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Neighbors Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 811 West 2nd Byron, IL 61010	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 1:08 PM, V1 (Administrator) said V26 (Maintenance Director) did a sweep recently on all the mechanical lifts and we have new batteries on order. V1 said she was not sure if the lifts were safety checked. V1 said staff should not be using equipment if the emergency release is not working. V1 said staff should fill out a work order and place the lift by the maintenance room.</p> <p>On [DATE] at 2:45 PM, V26 (Maintenance Director) said about 2 days ago, he went through and checked out all the mechanical lifts, and they should now be in working order. V26 with this surveyor, found the mechanical lift with the unattached emergency release ring and said the ring should be attached.</p> <p>The facility's undated Maintenance Service Policy shows the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents records were up to date and accurate. This applies to 3 of 12 residents (R34, R35 & R36) reviewed for resident records in the sample of 41.</p> <p>The findings include:</p> <p>1. On [DATE] at 11:17 AM, V34 (R34's daughter) stated, R34 was on his way to an appointment in the transport van and flipped backwards in his wheelchair and hit his head.</p> <p>On [DATE] at 11:33 AM, V19 (Former Maintenance Director) stated, R34 did flip backwards in the transport van on the way to an appointment.</p> <p>On [DATE] at 11:57 AM, R34 stated, he remembered the guy flipping him backwards in the van on the way to his appointment.</p> <p>R34's electronic medical record (EMR) does not show any documentation nor provide any documentation regarding R34's incident in the transport van.</p> <p>On [DATE] at 12:57 PM, V1 (Administrator) stated, the nurses should be documenting any incidents with a progress note and all assessments should be in medical record.</p> <p>The facility's fall prevention and management dated [DATE] shows, Documentation: In the medical record, document the vent, outcome, and initial and ongoing observations, and update fall risk assessment and care plan. Documentation includes notification of licensed independent practitioner and resident's representative.</p> <p>2. On [DATE] at 9:22 AM, V36 (Licensed Practical Nurse/LPN) said R35 walked out the 500-hall dining room door and was outside of the building on the sidewalk. V36 said staff heard the alarm sound and went outside. V36 said staff were able to bring R35 back into the building and R35 did not have any injuries. V36 could not remember the date of the event, but said it was about one year ago. V36 said she notified V1 (Administrator) about what happened, and V1 told her to hold off on charting while they were trying to figure it out. V36 said V1 did not say why she was not supposed to chart, but this was something that should be charted. V36 said she did notify V40 (R35's Power of Attorney) about the event and V40 declined to move R35 to the memory care unit at that time. V36 said R35 was able to walk with a walker and did look for exits to go home.</p> <p>On [DATE] at 1:08 PM, V1 (Administrator) said she did not recall any event where R35 got out of the building. V1 said that would be something that would need to be charted in the progress notes.</p> <p>On [DATE] at 1:35 PM, R35 was sitting in her room with V40. V40 said R35 does like to wander around the facility. V40 said the facility did call her about a time when her mom got out of the building.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 11:10 AM, V16 (Social Service Director) said she was not aware of an incident with R35 going out of the building. V16 said that was something that should be charted and then investigated to make sure appropriate interventions are put in place for resident's safety.</p> <p>The facility was unable to provide any documentation regarding R35 exiting the building.</p> <p>The facility's Missing Residents Policy dated 5/17 shows Facility must report and investigate all reports of missing residents. It is the responsibility of all personnel to report any resident not authorized to leave the facility attempting to leave the premise or suspected of being missing to the charge nurse immediately. Upon return of the resident to the facility, the charge nurse should: complete and incident report and make appropriate notations in the resident's medical records.</p> <p>3. On [DATE] at 9:55 AM, V22 (Certified Nursing Assistant/CNA) said on [DATE] she was toileting R36 using the sit to stand machine. V22 said she had R36 standing up with her arms above her head attached to the machine with the sling when she attempted to lower R36 to the toilet. V22 said the battery died and the machine wouldn't lower R36. V22 said she got other batteries and none of the batteries she tried were working. V22 said R36 was getting weak and starting to panic, so she tried to use the emergency release on the machine, and it wouldn't release. V22 said she had to put her knees under R36's bottom, and with a gait belt around R36's waist, manually lower R36 to the wheelchair. V22 said she told the nurse on duty.</p> <p>On [DATE] at 11:34 AM, V10 (LPN) said she was the nurse on duty on [DATE] when the sit to stand machine malfunctioned with R36. V10 said she told V16 (Social Service Director) who was the manager on duty about the incident. V10 was not sure if she charted anything.</p> <p>On [DATE] at 11:39 AM, V16 said she spoke with V10 and V22 that day about the incident and let V1 (Administrator) and V2 (Assistant Director of Nursing) know about it. V16 said she didn't chart anything about the incident.</p> <p>R36's medical records do not contain any documentation of an incident with R36 on [DATE] with a sit to stand machine.</p> <p>On [DATE] at 1:08 PM V1 (Administrator) said V16 did notify her of the incident with R36 and the sit to stand machine and there should have been a progress note made about the incident.</p> <p>The facility's undated Charting and Documentation Policy shows The purpose of charting and documentation is to provide: A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., as well as the progress of the resident's cares. Assistance in the development of a Plan of Care for each resident.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure mechanical lift equipment was in good working order for 5 of 5 residents (R8, R19, R36, R40, R41) reviewed for mechanical lifts in the sample of 41.</p> <p>The findings include:</p> <p>On [DATE] at 9:55 AM, V22 (Certified Nursing Assistant/CNA) said on [DATE] she was toileting R36 using the sit to stand machine. V22 said she had R36 standing up with her arms above her head attached to the machine with the sling when she attempted to lower R36 to the toilet. V22 said the battery died and the machine wouldn't lower R36. V22 said she got other batteries and none of the batteries she tried were working. V22 said R36 was getting weak and starting to panic, so she tried to use the emergency release on the machine, and it wouldn't release. V22 said she had to put her knees under R36's bottom, and with a gait belt around R36's waist, manually lower R36 to the wheelchair. V22 showed this surveyor a mechanical lift in the resident hallway and pointed out the red emergency release ring was not connected to the shaft and slid up and down with no effect. V22 said this is broken, the emergency release should be connected to the shaft. V22 said they didn't have reliable equipment and staff have let the management know.</p> <p>On [DATE] at 9:37 AM, V38 (CNA) said the batteries for the mechanical lifts don't stay charged. V38 said about 2 weeks ago, during a mechanical lift transfer with R8, the battery died while R8 was in the sling in the air over the bed. V38 said they had to try multiple batteries before they finally were able to get one that worked and complete the transfer.</p> <p>On [DATE] at 9:40 AM, V25 (CNA) said staff is very frustrated over having to run to get new batteries. V25 said you leave one person with resident up in sling and then one person runs to get new battery. V25 said some mechanical lifts have messed up wheels, and some the emergency release doesn't work. V25 said R19 and R41 use sit to stand machine for transfers.</p> <p>On [DATE] at 10:35 AM, V22 (CNA) said R40 is a mechanical lift for transfers.</p> <p>On [DATE] at 9:50 AM, R41 was sitting up in his wheelchair in his room watching TV. R41 said they use a sit to stand machine to help him move from the wheelchair to bed and back. R41 said there have been many times while he was attached and up in the machine that the battery dies, and they must get another to swap out.</p> <p>On [DATE] at 1:08 PM, V1 (Administrator) said V26 did a sweep recently on all the mechanical lifts and we have new batteries on order. V1 said she was not sure if the lifts were safety checked. V1 said staff should not be using equipment if the emergency release is not working. V1 said staff should fill out a work order and place the lift by the maintenance room.</p> <p>On [DATE] at 2:45 PM, V26 (Maintenance Director) said about 2 days ago, he went through and checked out all the mechanical lifts, and they should now be in working order. V26 with this surveyor, found the mechanical lift with the unattached emergency release ring and said the ring should be attached.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's undated Maintenance Service Policy shows the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.</p>		