STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145440	A. Building B. Wing	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neighbors Health Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident was assessed for a change of condition of 1 of 3 residents (R3) reviewed for change of condition in the sample of 6. The findings include: R3's face sheet documents she was admitted to the facility on [DATE] with a primary diagnosis of pressure ulcer of sacral region, stage 4. She also had diagnosis of unspecified dementia, unspecified severity. The 10/6/24 quarterly resident assessment and care screening shows R3 to have severe cognitive impairment and required supervision/touch assistance for sit to stand and toilet transfers. The same assessment documents her to be occasionally incontinent of urine and frequently incontinent of bowel. On 5/23/25 at 1:40 PM, V10 (Certified Nursing Assistant/CNA) said R3, for the most part, she was confused, and she needed stand by assist. She was always trying to get up out of bed on her own, and she had alarms so we could know when she was moving. V10 said remembers, R3 she was just laying down. We would check on her and poke our heads in to check on her, and she did not get up once, that was unusual. V10 reported this to the nurse and left at the end of her shift. On 5/23/25 at 1:51 PM, V11 (CNA) said R3 was confused, but knew her name. She could let us know if she needed to go to the bathroom. She would be up and down to the bathroom every 4 minutes. She would put her light on and if you were not right there, she would just get up and go. V11 said she came in for 2nd shift, the day R3 was sent out to the hospital. She said during her afternoon shift, R3 did not get up, did not put on her call light, and would not sit up. She said the nurse on the unit was notified of the change. She recalled V5 (Licensed Practical Nurse/LPN) was the nurse on duty, but the only response the nurse had was her vital signs are fine. She said when the night shift nurse came in at 6:00 PM, she reported the changes to her, and R3 was immediately sent out to the hospital. R3's progress notes for 11/24/24 at 6:06 AM show staff reported possible blood in urine this morning. Difficult to tell due to large bowel movement. Will hand off to oncoming nurse. The progress notes show no further assessment or progress notes until 10:38 PM, when R3 was being sent out to the hospital. The vital sign results for 11/24/24 show V5 checked R3's vital signs at 10:28 AM, 2:13 PM, and 5:15 PM. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/23/25 at 2:45 PM, V5 (LPN) said she did not recall R3. She said she did not recall being told about possible blood in the urine. She did not recall why she took vital signs three times during her shift. She said she would not document anything if nothing was wrong, sometimes she just monitors residents. On 5/27/25 at 2:50 PM, V16 (Registered Nurse) said, if she received in report there was a resident experiencing a change of condition, off their baseline and having blood in their urine, she would frequently assess the resident, get vitals, and notify V18 (Nurse Practitioner) of any findings. V16 stated she would do a full head to toe assessment, document those assessments and notifications start to finish. V16 stated it would be important to do that to maintain full circle of communication for the care of the resident. If it isn't charted it didn't happen. On 5/27/25 at 3:21 PM, V18 (Nurse Practitioner) said if a resident possibly has blood in their urine, she should be informed about that. She would have checked for fever, vitals, chills, and/or pain. She said R3 had dementia could voice her concerns, maybe not 100 percent reliable but she could tell. She said she probably would have ordered a straight catheter to check the urine, but the nurse should have had some follow up. The nurse should have been documenting outputs if she was eating or drinking. After reviewing the charting and vital signs, she said it appears the nurse was concerned about something as it was not usual to check vital signs multiple times a shift and not have any documentation of an assessment. On 5/27/25 at 1:40 PM, V2 (Director of Nursing) said for any resident with a possible change of condition or concern, V18 should be notified. She recalls R3 to have behaviors of repeatedly getting up. If there was any change with her, she would expect the aides to report to the nurse, and the nurse to follow up an assessment. V2 said she does recall the situation and believes the aides on duty did get their mother (another nurse on duty) to look at R3, if that in fact did occur, there should have been documentation from her in the record. The facility's 2/2025 policy for Change in a Resident's condition or Status documents the objective as: Our facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's condition and/or status. 5. The nurse will record in the resident's medical record any changes in the resident's medical condition or status.