STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145464	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hammond-Henry District Hsp	600 North College Avenue Geneseo, IL 61254

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observation, record review, and interview the facility failed to protect a resident from abuse/mistreatment-specifically, V3/Certified Nursing Assistant-CNA was physically rough when providing incontinence care for one resident (R1) of three residents, reviewed for abuse, in a total sample of three residents. This failure resulted in V3 being physically abusive to R1 which caused R1 to clench her teeth, grimace, moan, cry, cover her face, and attempt to take a protective/defensive position.This failure resulted in an Immediate Jeopardy.While the immediacy was removed on 10/8/25, the facility remained out of compliance at a Severity Level 2 as additional time is needed to evaluate the implementation and effectiveness of the facility's removal plan and quality assurance monitoring. Findings include:The Facility abuse policy, entitled LTC Abuse & Neglect Procedures, reviewed 5/3/2021, documents: Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.R1's Electronic Medical Record/EMR document: R1 is not cognitively intact and has a diagnosis of Alzheimer's Disease, Osteoarthritis, Anxiety Disorder, Hypothyroidism, Hemorrhoids, Lyme's Disease, Restlessness and Agitation, Hypertension, Hyperlipidemia, and Depression. On 10/1/25, at 12:30 a.m., a video recording (taken in R1's room) shows during incontinence care: V6/CNA and V3 provided cares; V3 pressed and held R1's hand down on R1's chest; adjusted R1's legs roughly; pressed R1's hand into R1's chest a second time-pushing down twice and R1 stated, I didn't do anything.; V3 roughly adjusted R1's legs again and R1 reached toward V3 and V3 pressed R1's hand back to R1's chest; V3 wiped R1's perineal area forcefully causing R1 to grimace and moan to which V3 responded Sorry, this is what your daughter wanted.; V3 finished incontinence care and pulled on R1's incontinence brief three times firmly enough that R1's body jerked upwards in bed while R1 continued grimacing.On 10/1/25, at 2:13 a.m., a video recording (taken in R1's room) shows: V3 and V6 providing cares; R1's shirt was wet; V3 firmly/roughly pulled R1's shirt off; R1 started crying while covering R1's face with R1's hand; V3 tied the gown and then without lifting R1's head, pulled it over R1's head which caused R1's head to tilt upwards and R1 grimaced.V6's statement to the facility, on 10/2/25, It wasn't just that resident, it was all of them. She was harsh and rough with people. She would snatch them and treated all of the residents like this.On 10/3/25, at 8:30 a.m., V2/Director of Nursing confirmed, in the 10/1/25 video recording which was taken in R1's room, V3 was abusive to R1 and V3's employment was terminated.On 10/7/25, at 9:30 am, V6 stated, during R1's cares, on 10/1/25: (V3) was Horribly rough and mean; overly aggressive, harsh, and unkind; way too hard; Resident (R1) was defensive and in protection mode.; I tried to reassure (R1), but (R1) was stressed with (V3) and that is the reason (R1) was combative because of the harsh treatment. Before we (V3) and (V6) went into the room, (V3) told me to keep my mouth shut and follow her lead. When asked if she felt V3 was abusive, V6 replied, Yes, (V3) was way out of line; and No, I did not report it because as agency, it was my word against hers (V3).The Immediate Jeopardy was identified to have begun on 10/1/25, at 12:30 a.m., when V3 was abusive to R1 during cares. On 10/07/25 at 3:35 p.m. V1/Chief Nursing Officer, V2/Director of Nursing-DON, V15/Risk Manager, and V16/Chief Executive Officer were notified of the Immediate Jeopardy.On 10/08/25 at 10:56 AM the facility submitted the abatement plan. On 10/08/25 at 1:48PM a phone conversation was had with the Facility concerning the submitted abatement plan.On 10/08/25 at 3:16PM the Facility submitted a revised abatement plan.On 10/08/25 at 4:22PM the Regional Office requested a revision to the abatement plan.On 10/08/25 at 5:04PM the Facility submitted a revised abatement plan.On 10/09/25 at 8:37AM the Regional Office requested a revision to the abatement plan.On 10/09/25 at 9:11AM the Facility submitted a revised abatement plan.On 10/09/25 at 10:31AM the Regional Office requested a revision to the abatement plan.On 10/09/25 at 11AM the Facility submitted a revised abatement plan, and the abatement plan was accepted.On 10/09/25 the surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy:1.On 10/2/25, V3's employment, with the facility, was terminated.2.10/2/25 at 1150 V2/DON and V15/Risk Manager performed visual assessment of resident (R1) for signs of physical and emotional abuse, no physical marks noted and patient's emotional status unchanged.3.On 10/8/25 V1/Chief Nursing Officer-CNO, V2, and V15 reviewed LTC/Long Term Care Abuse and Neglect Procedures Policy as well as the organization's Behavior Standards.4.V2 reviewed the LTC Abuse and Neglect Procedures Policy and Behavior Standards with the V18/Assistant Director of Nursing-ADON and then all staff on shift on 10/08/25

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observation, record review, and interview the facility failed to report an allegation of abuse to the abuse coordinator and the State Agency for 2 residents (R1 and R2) of three residents, reviewed for abuse, in a total sample of three residents. These failures resulted in V3/Certified Nursing Assistant-CNA continuing to be abusive to R1 which caused R1 to clench her teeth, grimace, moan, cry, cover her face, and take a defensive/protective posture.This failure resulted in an Immediate Jeopardy.While the immediacy was removed on 10/08/25, the facility remained out of compliance at a Severity Level 2 as additional time is needed to evaluate the implementation and effectiveness of the facility's removal plan and quality assurance monitoring.Findings include:The facility policy, entitled LTC Abuse & Neglect Procedures, Last Periotic Review 5/3/2021, documents: a. All incidents and allegations will be reported immediately. d. The Nurse Manager will ensure that all alleged violations involving abuse, are reported immediately, but not later than 2 hours after any allegation made if the events that cause the allegation involve abuse or cause serious bodily injury 24 hours if the allegations do not involve abuse or do not result in serious bodily injury, to administrator of the facility and to other officials (including to the State Survey Agency.R1's Electronic Medical Record/EMR document: R1 is not cognitively intact and has a diagnosis of Alzheimer's Disease, Osteoarthritis, Anxiety Disorder, Hypothyroidism, Hemorrhoids, Lyme's Disease, Restlessness and Agitation, Hypertension, Hyperlipidemia, and Depression.R2's EMR documents R2 is cognitively intact with a Brief Interview for Mental Status as 14/15 and has a diagnosis to include: Polyneuropathy, Unspecified Dementia, Chronic Obstructive Pulmonary Disease, Urinary Tract Infection, Iron Deficient Anemia, Hypertension, Chronic Kidney Disease Stage 3, Hypercholesterolemia, Hypothyroidism, Generalized Osteoarthritis, Presence of Cardiac Pacemaker, and Weakness.Facility Document entitled Corrective/Disciplinary Action, dated 02/24/25, documents: It was previously verbally discussed with (V3) that a resident reported she was being rough during a transfer. Concerns were brought forth that she is being rough during rounds and changing.Facility Document entitled Corrective/Disciplinary Action, dated 07/23/25, document: It was reported to Manager on 7/24/2025 that a R2 stated that (V3) was rough during cares; (V3) was rough doing peri care. V3 has violated behavioral standards through these actions. 7/24/25 at 6:26 p.m.- (V8/Registered Nurse) notified (V2/Director of Nursing) that resident (R2) reported that (V3) was rough with her last night and hurt her; (V8) stated, Resident said (V3) pulled her clothes off roughly. R2 said she told (V3) that she was slipping off the toilet and tried to grab the bar. (V3) told her she was fine and didn't need to hold the bar. (R2) said (V3) grabbed her roughly.; (R2) stated (V3) started to undress her and pulled the shirt and jacket off at the same time over the head instead of separately. Resident reported she thought it was going to make a spot on her head bleed. Resident reported she was almost shaking. Resident said, seems like she doesn't like me, I don't like her. Resident reports some nights she is nice. Some nights she is ferocious. Resident stated she didn't know if she could sleep that night but stated she did. Resident stated (V3) has a horrible attitude and I don't know what her problem is. I don't know if it's just me. Resident reports one time she pushed her through the privacy curtain without opening it and the resident hit her on the door.Email communication sent from V4/CNA, witness to 7/24/25 incident, to V2: (V3) and I went into (R1's room) during first rounds to check and change the resident. I grabbed the blue cushion to use and (V3) asked why I was grabbing it to use. I said that we had to use it or at least attempt to use it. (V3) then said, No we don't. and I just nicely mentioned that (R1's daughter would like us to use it or attempt to. I mentioned that (R1's daughter) can see if we are using it or attempting to use it through the camera. (V3) shook her head and said that the daughter was an idiot for coming into the facility with poison ivy on her arms and contaminating everybody, loudly. I said that I was going to stop talking because we were on camera. She said she didn't give a sh*t, I said Well I do. After the conversation was over, she was also somewhat very rough with resident when it came time to do peri care on her.On 10/1/25, at 12:30 a.m., a video recording (taken in R1's room) shows during incontinence care: V6/CNA and V3 provided cares; V3 pressed and held R1's hand down on R1's chest; adjusted R1's legs roughly; pressed R1's hand into R1's chest a second time-pushing down twice and R1 stated, I didn't do anything.; V3 roughly adjusted R1's legs again and R1 reached toward V3 and V3 pressed R1's hand back to R1's chest; V3 wiped R1's perineal area forcefully causing R1 to grimace and moan to which V3 responded Sorry, this is what your daughter wanted.; V3 finished incontinence care and pulled on R1's incontinence brief three times firmly enough that R1's body jerked upwards in bed while R1 continued grimacing.On 10/1/25, at 2:13 a.m., video recording, taken in R1's room

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure staff change gloves during incontinence care for one resident (R1) of three residents, reviewed for incontinence care, in a total sample of three.Findings include:The video recording, taken in R1's room, on 10/1/25, at 12:30 a.m., shows V3/Certified Nursing Assistant-CNA (employment terminated and unavailable for interview) providing incontinence care (with the assistance of V6/CNA) to R1. Without changing gloves, V3: lowered the bed; pulled down the blankets; pulled out the pillow from underneath R1's buttocks; checked for incontinence; rolled up the reusable incontinence pad from under the resident; rolled R1 to her left side; removed the pillow from between R1's legs; lifted R1's legs and set them on a blue holder; went to R1's closet, reached in, pulled out a clean incontinence brief; walked into R1's bathroom and immediately walked out and went to R1's bed; touched the end of the bed; lowered the head of the bed; placed a clean incontinence brief on R1's bed; walked back to the bathroom; came back out; placed wipes on the bedside table; walked back to the bathroom. walked back to the bedside table with a spray; grabbed the incontinence wipe and threw it on the bed; lifted R1's legs to adjust them; grabbed the wipe and cleaned R1's perineal area; threw the dirty wipe down; grabbed a clean wipe; wiped R1's perineal area; threw the wipe away; grabbed a clean wipe; grabbed paper towels and dried R1's perineal area; adjusted R1's legs and rolled resident over; removed soiled incontinence brief; grabbed a couple clean wipes and wiped R1's buttocks several times; discarded dirty wipe; grabbed a clean wipe; dried R1's buttocks again; discarded dirty wipe; grabbed paper towels and dried R1's buttocks; discarded the paper towels; adjusted the incontinence pad; grabbed the new incontinent brief; tucked the brief under R1; placed the new incontinence brief on R1; removed blue foam pad from under R1's legs and repositions R1; adjusted pillows, blankets, and bed alarm; threw gloves in the trash; pulled out the old trash bag; put a new trash bag in the trash can and then V3 left R1's room. On 10/9/25, at 11:05 a.m., V2/Director of Nursing would not confirm V3 should have changed gloves, from soiled body site to a clean body site, but rather the expectation is to perform hand hygiene for five minutes between dirty to clean surfaces. Per the Center for Disease Control/CDC, glove changes should occur when: If gloves become soiled with blood or body fluids after a task; If moving from work on a soiled body site to a clean body site on the same patient or if a clinical indication for hand hygiene occurs; If moving from care on one patient to another patient; and If they look dirty or have blood or body fluids on them after completing a task.