

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2025
NAME OF PROVIDER OR SUPPLIER McLean County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 901 North Main Normal, IL 61761	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent misappropriation of resident property for one of three residents (R89) reviewed for misappropriation in the sample list of 38. Findings include: R89's Facility Census documents R89 was admitted to the facility on [DATE] at 12:08pm. R89's Minimum Data Set (MDS) dated [DATE] documents R89's Brief interview for Mental Status (BIMS) 14, cognitively intact. R89's Facility's Observation Detail List Report dated 5/23/25 at 11:55am completed by V17 Social Service Assistant documents inventory of R89's Personal Items as Wallet/Purse/Checkbook, describe, including contents. Yes-wallet, cards and cash. No duffel bag was inventoried. R89's Credit Card Statement documents the following charges 6/3/25 \$41.00, 6/10/25 \$48.14, 6/13/25 \$41.00, 6/19/25 \$51.03, and 6/25/25 \$47.02 at a local gas station. R91's Facility Census documents R91 was admitted to the facility on [DATE] at 1:00pm. R91's Facility's Observation Detail List Report dated 5/21/25 at 4:20pm completed by V17 Social Service Assistant: Documents Inventory of R1's Personal Items: Wallet/Purse/Checkbook, describe, including contents. No. The Facility's Abuse Prevention Policy and Procedure regarding, Abuse and Neglect, Involuntary Seclusion, Misappropriation of Resident Property, Resident Altercations, Injuries of Unknown Origin and social media. Revised 1/2025 documents: Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subject to abuse by anyone, including, but not limited to; facility staff, other residents, consultants, volunteers, or staff or other agencies serving the resident, family members, legal guardians, visitors or other individuals. The Facility's Non-Clinical admission Procedure not dated documents: Nursing Home will maintain the capability of admitting residents 24 hours a day. Nursing Home will collaborate with referring entity to ensure the admission times are in the best interest of the residents, as much as practicable. Upon Arrival of admission: 4. Complete Personal Inventory Observation. On 8/12/25 at 10:59am R89 stated that on 5/23/25 R89 was admitted to the facility from the hospital. R89 stated that while being admitted by V17 Social Service Assistant, V17 asked to inventory R89's personal property. R89 stated that R89 had a blue duffel bag with some clothes in it, a clear plastic bag with toiletries and had R89's wallet and keys in R89's pants pocket. R89 stated that R89 gave V17, R89's wallet which was black with a hole in it. R89 stated that it contained \$200.00 United States Currency, credit card, Illinois Driver's License, insurance card, Illinois Firearms Identification Card (FOID) and grocery store cards. R89 stated that R89 also gave V17 R89's house keys. R89 stated that on 6/29/25 R89's Son came to the facility and brought R89's credit card bill, and there were charges on 6/3/25 for \$41.00, 6/10/25 for \$48.14, 6/13/25 for \$41.00, 6/19/25 for \$51.03 and 6/25/25 for 47.02 at a local gas station. R89 stated R89 was a resident in the facility, and did not, and could not make these charges. R89 stated R89's credit card and money were supposed to be locked up in the social</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>service office. R89 stated on 6/30/25 at 8:40am, R89 spoke to V18 Social Service Director, and asked to get R89's wallet to check to make sure R89's credit card was in R89's wallet. R89 stated V18 could not locate R89's wallet or keys in the Social Service Office. R89 stated V1 Administrator was notified, and an investigation was started, and the local police department was called. On 8/12/25 at 12:54 pm V17 Social Service Assistant stated on 5/23/25 V17 was assisting V18 Social Service Director with admitting R89 and R91. V17 stated R89 told V17 that R89 had a wallet. V17 stated that when completing R89's inventory sheet, V17 did document that R89 had a wallet, cards and cash. V17 stated that this was in error. V17 stated that V17 accidentally forgot to delete this entry after admitting the R91, who did have a wallet. V17 confirmed that R89's property inventory did document that R89 had a wallet, and that V17 typed that it contained cards and cash. V17 confirmed that R89's inventory sheet documents that R91 did not have a wallet. On 8/12/25 at 1:08pm V18 Social Service Director stated on 6/30/25 at around 8:40am V89 approached V18 and requested to see R89's wallet. V18 stated that R89 described it as black with a hole in it, and had about \$200.00 cash in it, credit cards, and that R89 also had keys locked up. V18 stated R89 wanted to make sure R89's credit card was in R89's wallet. V18 stated that R89 informed V18 that R89 had some charges put on R89's credit card and doesn't know why. V18 stated that R89 wanted to make sure R89's credit card was in still in R89's wallet. V18 stated that V18 didn't recall R89 giving V18 a wallet and asked who R89 gave it to. R89 stated R89 gave it to V17 Social Service Assistant. V18 could not locate the wallet/keys in Social Service office. V18 looked in the safe in the front office and it was not there. V18 searched R89's room with R89 present and did not locate a wallet or keys. V18 stated V18 immediately notified V1 Administrator. On 8/13/25 at 11:50am V1 Administrator stated on 6/30/25 V18 Social Service Director informed V1 that V18 could not locate R89's wallet that R89 gave to V17 Social Service Assistant when R89 was admitted to the facility on [DATE]. V1 stated on 6/30/25 V1 Administrator interviewed R89 who said that the day before (6/29/25) V23, R89's Son, brought in R89's credit card statement, and R89 noticed that there were five charges on the credit card that were suspicious and were charged while R89 was in the nursing home. V1 stated R89 asked V18 if R89 could see R89's wallet to make sure R89's credit card was still present. V1 stated that V18 could not find R89's wallet or R89's keys. V1 stated R89 was understandably very anxious about the missing items. V1 stated that R89 called the bank and the bank informed R89 there were five charges in June totaling \$227.19, and all charges were at a local gas station/convenience store. V1 stated on 7/2/25 V1 and V18 interviewed V17. V1 stated V17 said on 5/23/25, V17 was completing the admission process for R89 and that the inventory included wallet, cards, cash. V1 asked V17, if R89 didn't have a wallet with R89, why did you put it on the inventory. V1 stated that V17 said that V17 was doing two admissions that day (R89 and R91) and documented the wrong person. V1 said, the were no other residents admitted to the facility on (May 23rd). V1 confirmed that R89's admission inventory documents that R89 had a wallet with cash and cards in it, and that R91's admission Inventory documents that R91 did not have a wallet.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain a resident's personal hygiene by failing to ensure routine fingernail care was completed for one of three residents (R64) reviewed for Activities of Daily Living (ADL) on a sample list of 38. The facility's ADL policy dated February 2025 documents under Policy Explanation and Compliance Guidelines #3.) A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Grooming includes, but is not limited to hair care, shaving and or facial hair care. R64's Minimum Data Set (MDS) dated [DATE] documents R64 scored a ten on her Brief Interview for Mental Status (BIMS). A BIMS score of eight to twelve indicates moderate cognitive impairment with potential need for help with daily tasks. R64's care plan dated 6/17/25 documents R64 has limited ability with ADLs and requires assistance with ADLs due to impaired cognition, general weakness and pain related to diagnoses of Alzheimer's, Ulcerative Colitis, and Low Back Pain. This care plan documents that the staff will assist R64 with showering twice weekly and partial bathing twice a day. The care plan documents staff will also assist with face, upper and lower body, hair, lotion and nail care. On 8/10/2025 at 11:49AM, R64 was sitting in R64's wheelchair near the 300 hall nurses' station. R64's fingernails were jagged and untrimmed, with brown material beneath the nails. On 8/12/25 at 10:00 AM, R64 was sitting in her wheelchair near the 300 hall nurses' station and her fingernails remain untrimmed with brown material beneath her nail. On 8/12/25 at 10:05 AM, V16 Certified Nursing Assistant (CNA) stated that the shower aides are responsible for providing nail care with the residents' shower. V16 stated R64 had a shower on Saturday, August 10, 2025, and R64's nails should have been cleaned and trimmed then, and it doesn't look like it was done. R64's Care Plan documents R64 is dependent for care and received shower/bathing assistance on the following dates and times: 8/09/2025 at 2:39 PM, 8/10/2025 at 2:53 PM, and 08/11/2025 at 2:51PM. On 8/12/25 at 11:24 AM, V19 Certified Nursing Assistant stated that V19 did not give R64 a shower on 8/10/25 but does know that R64 got a shower because V19 did the documentation. V19 stated the shower aides are responsible for cleaning beneath the nails after the shower and as needed and that R64's nail care should have been done on 8/10/25. V19 stated that it is hard to keep R64's nails clean because R64 digs in her pants and scratches at R64's skin making it difficult to maintain clean nails. On 8/12/25 at 11:30 AM, V20 Certified Nursing Assistant/Shower Aide stated the expectation is that the shower aide will provide nail care which includes removing dirt/debris from beneath the nail with every shower and as needed and that R64 should have had that done on her last shower day.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement Enhanced Barrier Precautions by failing to wear Personal Protective Equipment when emptying an internal urinary drainage device and failed to maintain urinary drainage bags off the floor, in a dignity bag, and away from potentially contaminated surfaces. This failure affects three of five residents (R9, R26, R48) reviewed for infection control on a sample list of 38. Findings include:</p> <p>The Urinary Catheter Policy and Procedure dated February 2025 documents that care shall be taken to avoid contact of the drainage tube with anything that could contaminate it.</p> <p>1. On 8/12/25 at 10:00 AM, R9 was in R9's wheelchair propelling down the hall. R9's urinary drainage bag was dragging on the floor as R9 moved down the hall.</p> <p>On 8/12/2025 at 2:22 PM, R9 was in the dining room with other residents participating in an activity and R9's urinary drainage bag was beneath R9's wheelchair and resting on the ground.</p> <p>R9's Care Plan dated 6/27/25 documents R9 requires an internal urine drainage device due to obstructive uropathy. This Care Plan documents the approach to this problem is that staff are to avoid allowing tubing or any part of the drainage system to touch the floor.</p> <p>R9's Care Plan dated 7/21/25 documents R9 requires enhanced barrier precautions (EBP) related to internal urine drainage device. This Care Plan documents that R9 and staff will be taught the chain of infection, methods of transmission and principles of infection control.</p> <p>2. R26's Care Plan dated 6/13/25 documents R26 requires an internal urine drainage device related to Flaccid Neuropathic Bladder. This Care Plan documents that staff are to avoid allowing tubing or any part of the drainage system to touch the floor.</p> <p>R26's Care Plan dated 8/5/25 documents R26's need for EBP related to internal urine drainage device. This Care Plan documents that EBP will be used to reduce the transmission of multidrug-resistant organisms. This Care Plan also documents that R26, and staff will be taught the chain of infection, methods of transmission and principles of infection control.</p> <p>On 8/12/2025 at 2:22 PM R26 was in the dining room with other residents participating in an activity and R26's urinary drainage bag was hanging beneath R26's wheelchair and resting on the ground.</p> <p>On 8/13/25 at 1:22 PM, V2 Director of Nursing (DON) stated urine drainage bags should never be resting on the ground.</p> <p>3. R48's Minimum Data Set (MDS) dated [DATE] documents R48 is alert and oriented, R48 requires assistance with R48's indwelling urinary catheter with a diagnosis of long-term indwelling catheter and R48 is on Enhanced Barrier Precautions due to R48's indwelling catheter.</p> <p>On 8/11/2025 at 12:54 PM R48 was lying in bed with the urinary catheter bag hanging from the garbage can and the catheter bag was not in a dignity bag. V8 Certified Nursing Assistant was emptying R48's indwelling catheter drainage bag and was not wearing personal protective equipment.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/11/2025 at 12:55 PM V8 Certified Nursing Assistant stated R48 should have a dignity bag in place covering the drainage bag and the urinary drainage bag should not be hanging from the garbage can. V8 stated V8 should wear Personal Protective Equipment (PPE) when V8 empties R48's catheter bag.</p> <p>On 8/11/2025 at 12:56 PM V9 Licensed Practical Nurse stated V8 should have worn Personal Protective Equipment (PPE) when V8 emptied R48's catheter bag.</p> <p>On 8/13/2025 at 2:05PM V2 Director of Nursing stated Personal Protective Equipment (PPE) should always be worn when a resident is on Enhanced Barrier Precautions, and V8 should have worn Personal Protective Equipment (PPE) when V8 emptied R48's catheter bag. V2 confirmed that R48 is on Enhanced Barrier Precautions for R48's indwelling catheter.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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 essential resident-care equipment (toilet safety frames) was maintained in safe operating condition for two of two (R4, R70) residents reviewed for environment on a sample list of 38. 1.) The Toilet Safety Frame Owner's Manual dated February 2024 documents that the toilet safety frame should be checked regularly to make sure that it is securely locked onto the toilet. This manual also documents that safety precautions should be taken by always making sure that the safety frame is correctly and securely locked in place before use. R70's Minimum Data Set (MDS) dated [DATE] documents R70's Brief Interview for Mental Status (BIMS) score as 15. This score indicates R70 has normal cognitive function.R70's Electronic Medical Record (EMR) documents R70 has a diagnosis of repeated falls.R70's Care Plan dated 7/7/25 documents R70 is at risk for falling and requires staff assistance when toileting.R70's Care Plan dated 2/03/25 documents R70 has urinary incontinence and requires staff assistance when toileting.R70's Occupational Therapy Evaluation and Treatment Plan dated 8/8/25 document that R70 will safely perform toileting tasks using grab bars with moderate assistance and 25% verbal cueing.On 08/10/2025 at 9:55 AM, R70 stated her bathroom handrails around the toilet are wobbly and that R70 fell off the toilet recently but had no injury but that it scared R70. During this interview these handrails that were attached to R70's toilet seat were observed to be unsecure and moved around easily when grabbed.On 8/13/25 at 9:09 AM, V24 Physical Therapist stated R70 had a recent fall on 8/9/25 near the bathroom with no injury. V24 stated that his recommendation was that R70 always have stand-by assist (SBA) with transfers and ambulation. V24 stated that R70 definitely needs safety handrails around her toilet for balance and to assist with getting off the toilet even with SBA present. V24 stated that an unsecure handrail creates the potential for a fall.On 8/13/25 at 11:31 AM, V25 Certified Occupational Therapy Assistant (COTA) stated that she is currently working with R70 and that R70 needs toilet stabilizer bars to assist with safe transfers and balance. V25 stated a loose stabilizer bar could contribute to a fall.2.) The Bariatric Commode Owner's Manual dated April 9, 2020, documents that periodic visual inspection of this commode is recommended to ensure that all parts and hardware are secure, that components are in good working order and not worn, torn, frayed, or loose, and that there are no obstructions or impediments to normal, safe operation. The manual also documents this commode should be checked for fit and tightness of all nuts, bolts and knobs WEEKLY to ensure the commode is stable and safe to use.On 08/10/2025 at 10:30 AM, R4 stated he is concerned about the assistive bars that are in the bathroom attached to his toilet seat. R4 stated he doesn't feel safe on the toilet because these bars move around too much. During this interview these handrails that were attached to R4's commode were observed to be unsecure and moved around easily when grabbed.R4's MDS dated [DATE] documents R4's BIMS as 15. This score indicates that R4 has normal cognitive function.R4's EMR documents a diagnosis of repeated falls and weakness.R4's Care Plan dated 7/17/25 documents that R4 has difficulty transferring independently related to history of falls, general muscle weakness and pain. This Care Plan also documents that R4 is at risk for falling due to impaired mobility, decreased safety awareness, easily fatigued and pain related to diagnoses of Cerebrovascular Accident (CVA) with left sided weakness and history of falls. Interventions documented for this problem are that staff are to provide toileting assistance as needed and provide verbal reminders to R4 that R4 is not to ambulate/transfer without assistance.R4's Occupational Therapy Discharge summary dated [DATE] documents R4 requires skilled treatment interventions as follows: use of adaptive equipment and use of assistive device(s) in order to increase to highest level of function. This summary also documents R4 will safely perform toileting tasks using raised toilet seat 3 in 1 commode</p> <p>(continued on next page)</p>		

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