STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145546	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Zion Health & Rehab Center	1225 Woodland Drive Mount Zion, IL 62549

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. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain residents dignity by failing to provide toileting in a timely manner. This failure affected one of five residents (R1) reviewed for dignity/incontinence care on the sample list of 3. Findings include:R1's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview of Mental Status (BIMS) score of 15 out of a possible 15, indicating R1 has no cognitive impairment.The same MDS documents that R1 is always continent of bowel and bladder, and that R1 requires substantial/maximal assistance to transfer on and off the toilet.On 12/09/25 at 1:05 p.m., R1 stated, As far as staff, they have never provided rough care. On the other hand, there was an incident last week that really upset me. A CNA (later identified as V37, Certified Nursing Assistant), I don't know her name, brought my breakfast in and rudely dropped my tray on the bedside table. She was upset because I asked her if she would take me to the bathroom before I ate. She said, 'p** (urinate) your diaper, I am not your CNA, I don't have time.'R1 further stated, I don't believe this was abuse. I do believe this was humiliating and very disrespectful (R1 became tearful). R1 continued, My roommate (R13) can tell you this really upset me. I did not tell anyone else until after I ate breakfast. I was sitting in my own urine for what felt like an hour. After breakfast, another CNA came in and walked me to the bathroom. That girl (V37, CNA) has not been in my room since. I don't know if she was having a bad day or what the issue was. If it happens again, I will go straight to the nurse and report it.On 12/09/25 at 1:30 p.m., R13 stated, I do know there was a CNA (later identified as V37) that told R1 she would not take her to the bathroom before breakfast and said R1 should p** (urinate) in her diaper. Of course, this is a horrible thing to say. It made R1 very upset. It would make anyone upset. R1 was humiliated and tried to hold it until staff had time to take her.On 12/09/25 at 1:58 p.m., V18, Certified Nursing Assistant, stated, R1 was upset that a CNA had left her in a wet incontinence brief. I would be upset too. She told me about it after the fact. I think the CNA (V37) told her she was not R1's CNA, so she didn't take her to the bathroom because she was on trays (delivering meals) that day. It does not matter which residents we are assigned; we all know to take a resident when they ask. Yes, that is a dignity issue-being left to urinate in their brief. I did not hear that she was told to p** (urinate) herself.On 12/11/25 at 10:29 a.m., V24, Licensed Practical Nurse (LPN), stated, I was here and had heard about V37, CNA, telling R1 she couldn't take her to the bathroom. I did not hear that V37 told her to p** in her diaper. Absolutely, I would think that telling her to p** in her pants would be abuse. No one should tell any resident that. I did report this to the supervisor on duty. I did not see this as abuse. I did ask R1 if she felt abused, and she said she was just embarrassed that she peed on herself. I can't remember who the supervisor was that was working. R1 was tearful at the time. She was taken to the bathroom after somebody heard her crying. R1 was incontinent of urine that morning; she is never incontinent. V37 should have stopped passing breakfast trays and taken R1 immediately to the bathroom. V37 was not R1's CNA and was passing breakfast trays. She said she told R1's CNA (unidentified) that R1 needed to go to the bathroom. I was here and told the supervisor when I received R1's complaint. I think this was a significant dignity issue. The CNAs were educated to stop and take residents to the bathroom when they ask. They can't hold it very long and should not have to. I have not had any other issues with V37 or other CNAs toileting residents when they ask. V37 needed a refresher (repeat education).On 12/11/25 at 11:50 a.m., V25, CNA, walked R1 to the bathroom and provided peri-care assistance. R1 voided continent of urine. R1's incontinence brief was dry, confirming R1 is continent of urine when toileted promptly.On 12/12/25 at 9:45 a.m., V37, Certified Nursing Assistant, stated, I brought R1 her breakfast tray, but I never told her to use the bathroom in her brief. I know she is usually taken to the bathroom. She did say something about needing to go to the bathroom and me getting her up. V6 (previous CNA) doesn't work here anymore. I think V6 was R1's CNA that day. I may have told R1 I would get her CNA. I just did not have time to do R1's morning care. Her CNA was supposed to get her up, dressed, and complete her morning care, which includes taking the resident to the bathroom. R1 was still in bed when she asked me to get her up to go to the bathroom. I did not take her. I was on hall trays (serving meals). I remember that. I thought I told V6, but I don't remember for sure. I was busy.The facility's Resident Rights Policy, dated 07/02/23, documents the following:PURPOSE:To provide guidance to facility staff on resident rights.POLICY:Employees shall treat all residents with kindness, respect, and dignity.POLICY INTERPRETATION AND IMPLEMENTATION:Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:a. a dignified existenceb. be treated with

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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 0602 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review the facility failed to ensure resident right to be free from staff to resident (R1) misappropriation of a credit card. R1 is one of three residents reviewed for abuse/misappropriation on the sample list 31. R1 experienced psychosocial harm, including emotional distress and tearfulness, as a direct result of the misappropriation of her credit card.Findings include:R1's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview of Mental Status (BIMS) score of 15 out of a possible 15, indicating R1 has no cognitive impairment.R1's Local Police Report, dated 11/24/25, documents that V6, Certified Nursing Assistant (CNA), was arrested by the local police department after using R1's credit card for purchases totaling $1,350.01, as verified by V16, local police detective. The same police report documents that V6, CNA, was charged with Aggravated Identity Theft Against a Person [AGE] years of age or Older or a Person with a Disability.On 12/09/25 at 1:05 p.m., R1 became tearful while discussing the details of the theft of her credit card. R1 stated she was the victim of theft by V6, a former Certified Nursing Assistant at the facility, who stole R1's bank card and charged over $1,000. R1 stated that V6, CNA, had been arrested. R1 also stated that the police were aware that V6, CNA, had sent R1 messages apologizing for stealing her credit card.On 12/10/25 at 10:15 a.m., V3, Regional Nurse Consultant, stated that the facility did not have an Administrator at the time R1 lost her bank card. It was confirmed through the police department and the police investigation that over $1,000 was charged on R1's bank card by V6, CNA.On 12/10/25 at 11:30 a.m., V16, Detective with the local police department, stated, My investigation regarding R1's bank card was complete. We had enough evidence, including camera footage, to arrest V6, CNA, for the theft.On 12/11/25 at 10:29 a.m., V24, Licensed Practical Nurse (LPN), stated, I heard about R1's bank card being stolen. I heard police were here. I don't know anything about the previous Administrator (V14) doing an investigation. Nobody talked to me about that. I do know R1 was very upset and became tearful when talking about this.The facility's Abuse Policy, revised 12/2025, documents the following:PURPOSETo provide guidance and procedures to the facility and staff to ensure residents remain free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff, or mistreatment.RESPONSIBILITYThe Administrator and/or designee is the facility's Abuse Coordinator. It is the responsibility of all facility staff to ensure that all residents remain free from abuse, including injuries of unknown origin, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff, or mistreatment. All staff are responsible for reporting any allegation or witnessed abuse immediately to the Administrator (Abuse Coordinator).

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F 0609 Level of Harm - Minimal harm or potential for actual harm 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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report misappropriation of an amethyst stone ring to Illinois Department of Public Health (IDPH), in a timely manner. This failure affected one of four residents (R12) reviewed for abuse/misappropriation on the sample list of 31.Findings include:R1's Minimum Data Set (MDS), dated [DATE], documents R1's Brief Interview of Mental Status (BIMS) score of 15 out of a possible 15, indicating R1 has no cognitive impairment.On 12/09/25 at 1:05 p.m., R1 became tearful while discussing the details of the theft of her credit card, which was investigated by the local police department. R1 then stated that her roommate, R13, could provide details about R12, who had a missing ring that occurred around the same time R1's credit card was stolen.On 12/09/25 at 1:30 p.m., R13 propelled her wheelchair into her shared room with R1. R13 stated, R12's family bought her a ring for her birthday just before Thanksgiving. She told the facility, and they looked for it but never found it. V18, Certified Nursing Assistant (CNA), knows all about it. R12 is still talking about it. She mentioned how important the ring was to her, and she is heartsick that it came up stolen.R12's MDS, dated [DATE], documents that R12's BIMS score at the time of the assessment was 5 out of a possible 15, indicating severe cognitive impairment.On 12/09/25 at 1:35 p.m., R12 stated, Someone stole the ring my grandchildren saved up to buy me for my birthday. I couldn't believe it. It happened a week or so ago. Staff searched for it but never found it. The police called here today and said they found two rings (could not confirm this). I don't know if I am missing two rings. I am waiting for a ride to go confirm which one is mine. I did not have two rings missing-at least I don't think I did. I am hopeful that one of the two the police found is mine.On 12/09/25 at 1:58 p.m., V18, Certified Nursing Assistant, stated, I heard about R12's ring missing last week. R12 told me when I gave her a shower. She was so upset. The Director of Nursing (V2) asked me if I had ever seen R12 wearing a ring. I could not say yes or no. I did look around her room and never saw it. I was told the Administrator at the time, V14 (Interim Administrator), already knew about R12's missing ring. I don't take care of her that often, so I really could not say if she had a ring. I can say she probably did, since it upset her so much when she talked to me.On 12/09/25 at 3:10 p.m., V2, Director of Nursing (DON), stated, Regarding R12, I recall V35, R12's family member, reported to staff that R12's ring was missing sometime before Thanksgiving. I heard about it in a morning meeting. I think V14, Interim Administrator, was there, but I can't be sure. I did not report or investigate R12's missing ring because everybody seemed to already know. I did not call the police at that time. I thought the Social Service Director (V17) had reported and investigated it. She was in the meeting and generally helps with investigations like that.On 12/10/25 at 10:05 a.m., V1, New Administrator/Abuse Prevention Coordinator, stated, I did not find documentation of any investigation regarding R12's missing ring. It does not appear to have been reported to IDPH or investigated. V1 provided the facility's initial misappropriation of property report to IDPH dated 12/10/25 at 10:00 a.m. The report documents that V35, R12's Power of Attorney/family member, reported R12's missing ring, which was last seen in November.On 12/11/25 at 11:30 a.m., V25, Certified Nursing Assistant (CNA), stated, I was R12's CNA the day her ring was discovered missing. I had taken her to the dining room, and another resident, R30, asked R12 if her ring was ever found. I was told it had been missing a few days before Thanksgiving. I was here on her birthday when she got the ring, so I know she had it. I told V26, Licensed Practical Nurse (LPN), about it. We did not have an Administrator at the time, as far as I know. I knew I was supposed to report it. V26 told me to write a report and slide it under V17's (Social Service Director) door. I wrote a statement, and V26 slid it under the door. I then went to R12's room and checked under the sheets, under her bed, on the floor, and through her dirty clothes. I did a thorough search and did not find anything. I reported all of that to V26. The ring was a silver band with a large purple amethyst stone. Her family brought it in for her birthday. I saw it several times. Nobody ever contacted me for additional details beyond my report. I received a call yesterday about it, but the ring went missing last week or the week before.On 12/10/25 at 10:25 a.m., V5, Dietary Manager, stated that V14 was the Interim Administrator and was present at a morning meeting. V14 asked housekeeping staff and CNAs to look for R12's ring. Within minutes, V25 was in R12's room looking for the ring.On 12/11/25 at 12:05 p.m., V17, Social Service Director, stated, I do recall a note about R12's ring missing. The note was not signed, or I could not read who wrote it. I did not think anything of it. I did not put it on the IDPH reportable log or the grievance log. I did call V35, R12's family member, but she didn't answer and her voicemail was full. I forgot about it. I did not report it to V14 because I did not think of this as abuse. It was

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to investigate two resident (R1 and R12) allegations of misappropriation. R1 and R12 are two of four residents reviewed for abuse/misappropriation on the sample list of 31.Findings include:1.) R1's Minimum Data Set (MDS), dated [DATE], documents R1's Brief Interview of Mental Status (BIMS) score of 15 out of a possible 15, indicating R1 has no cognitive impairment.On 12/09/25 at 1:05 p.m., R1 became tearful while discussing the details of the theft of her credit card. R1 stated the missing credit card was investigated by the local police department, who arrested V6, Certified Nursing Assistant (CNA), after their investigation found that V6 had charged over $1,000 to the card. R1 stated that V3, Regional Nurse Consultant, spoke with her but never spoke with her roommate, R13. R1 stated that R13 knew all about R1's stolen credit card and also knew about R12's missing ring around the same time.R13's MDS, dated [DATE], documents R13's BIMS score as 15 out of a possible 15.On 12/09/25 at 1:30 p.m., R13 confirmed she was with R1 at the time they believe the credit card was stolen by V6, CNA. R13 stated no one at the facility ever interviewed her regarding R1's credit card. R13 also stated she had knowledge of R12's missing ring, which R12 had received from her family and which went missing just before Thanksgiving. R13 stated no one asked her about that incident either.On 12/10/25 at 10:15 a.m., V3, Regional Nurse Consultant, stated the facility did not have an Administrator at the time R1's bank card went missing. It was later confirmed through the police department and their investigation that the card had been stolen and charges were made on the account. V3 stated she was responsible for the investigation but did not conduct it because she was busy managing nine other buildings at that time.2.) R12's Minimum Data Set (MDS), dated [DATE], documents R12's BIMS score of 5 out of a possible 15, indicating severe cognitive impairment.On 12/09/25 at 1:35 p.m., R12 was confused about the details but was insistent that a ring her grandchildren had given her for her birthday was missing.On 12/09/25 at 3:10 p.m., V2, Director of Nursing (DON), stated, Regarding R12, I recall V35, R12's family member, reported to staff that R12's ring was missing sometime before Thanksgiving. I heard about it in a morning meeting. I think V14, Interim Administrator, was there, but I can't be sure. I did not report or investigate R12's missing ring because everybody seemed to already know. I did not call the police at that time. I thought the Social Service Director (V17) had reported and investigated it. She was in the meeting and generally helps with investigations like that.On 12/10/25 at 10:05 a.m., V1, new Administrator/Abuse Prevention Coordinator, stated, I did not find documentation of any investigation regarding R12's missing ring. It does not appear to have been reported to IDPH (Illinois Department of Public Health) or investigated.The facility's initial misappropriation of property report to IDPH was dated 12/10/25 at 10:00 a.m. (during this survey). R12's ring had been missing since at least 11/21/25, per V35, R12's Power of Attorney/family member, who first reported the missing ring.On 12/11/25 at 11:30 a.m., V25, Certified Nursing Assistant (CNA), stated she searched for R12's ring after taking R12 to the dining room a few days before Thanksgiving. Another resident, R30, asked R12 if she had found her lost ring. V25 stated the ring was a silver band with a large purple amethyst stone and that R12's family had brought it in for her birthday. V25 stated she saw the ring several times. V25 reported the missing ring to V26, Licensed Practical Nurse (LPN), who directed V25 to write a note and slide it under V17's (Social Service Director) door. V25 stated she wrote the note and slid it under the door. V25 further stated no one ever followed up with her regarding R12's ring.On 12/10/25 at 10:25 a.m., V5, Dietary Manager, stated that V14, Interim Administrator/Abuse Prevention Coordinator, was present at a morning meeting. V14 asked housekeeping staff and CNAs to look for R12's ring.On 12/11/25 at 12:05 p.m., V17, Social Service Director, acknowledged she was aware of R12's missing ring but did not conduct an investigation because she was not directed to do so by V14, Interim Administrator.On 12/12/25 at 3:10 p.m., V35, R12's family member, stated, R12's ring has an amethyst stone at the center with small diamond stones surrounding it. It was given to her by her grandchildren for her birthday on 11/15/25. It was last seen when I visited on 11/21/25. The day before Thanksgiving (11/26/25), the ring was missing. I reported this to a CNA at the time, but I don't remember which one. She told me she would look for it. I didn't hear anything else from the facility until yesterday. I spoke with the current Administrator, V1, who said she would conduct an investigation. I'm not sure how the issue was missed previously. I thought they were still looking for it. The ring has been missing for weeks. The police department has since been called and reassured me they will conduct a thorough investigation. I sent a picture of the ring to the current Administrator and the local police department. I'm still

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement physician's orders for one of three residents (R9) reviewed for following plans of care on the sample list of 31.Findings Include:R9's Hospice admission Orders dated [DATE] document that R9 was admitted to hospice care. To protect R9's skin, staff were instructed to use incontinence pads instead of incontinence briefs.On [DATE] at 1:21 PM, V29, Licensed Practical Nurse (LPN), stated she was not aware that staff were supposed to use incontinence pads instead of incontinence briefs for R9.On [DATE] at 12:52 PM, V45, Certified Nursing Assistant (CNA), stated she was not aware that staff were supposed to use incontinence pads instead of incontinence briefs for R9.On [DATE] at 12:57 PM, V37, Certified Nursing Assistant (CNA), stated she was never told that R9 was to use incontinence pads instead of incontinence briefs and that she and other staff continued to use incontinence briefs until R9's death on [DATE].On [DATE] at 2:35 PM, V2, Director of Nursing, stated she did not know for sure whether the hospice order for staff to use incontinence pads instead of incontinence briefs was communicated to nursing or CNA staff. V2 confirmed this information should have been communicated to staff and that staff should have been following the physician's order to use incontinence pads instead of incontinence briefs.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 safely transport a resident resulting in two falls from the wheelchair. The facility also failed to document fall investigations for two falls. These failures affected one of three residents (R9) reviewed for falls on the sample list of 31. Findings Include:The facility's Accidents and Incidents Policy dated 7/1/23 documents that all accidents or incidents involving a resident will be documented in risk management, and the nursing team will complete an investigation that includes identification of the root cause and implementation of new interventions.R9's undated Medical Diagnoses List documents that R9 was diagnosed with Alzheimer's disease, adult failure to thrive, rhabdomyolysis, and unspecified abnormalities of gait and mobility.R9's Fall Risk assessment dated [DATE] documents that R9 was at high risk for falls due to being consistently disoriented, having one to two falls in the last three months, being chair-bound and/or requiring assistance, taking one to two high-risk medications, and having one to two high-risk medical diagnoses.R9's Care Plan dated 9/29/25 documents that R9 was at risk for falls and injuries related to adult failure to thrive, protein-calorie malnutrition, and Alzheimer's disease. R9 experienced three falls in September 2025 (9/11/25, 9/20/25, and 9/24/25). On 9/20/25, R9 fell, and a new intervention was added to the care plan directing staff to ensure the resident was positioned correctly in her wheelchair when being transported.R9's Progress Note dated 9/20/25 documents that shortly after 5:00 PM, staff member V45, Certified Nursing Assistant (CNA), attempted to transport R9 to the dining room. During transport, R9 fell forward out of her wheelchair.On 12/16/25 at 12:52 PM, V45, CNA, confirmed she transported R9 to the dining room when R9 fell from the wheelchair. V45 could not recall specific details but stated that R9's posture was curved forward and that she leaned forward constantly while seated. V45 also confirmed that R9 would attempt to stand during transport.R9's Progress Note dated 9/24/25 documents that R9 was in the hallway and was very restless, leaning forward in her wheelchair. V37, Certified Nursing Assistant (CNA), turned R9's wheelchair to take her to the dining room when R9 leaned forward and fell to the floor. R9 sustained a hematoma to the right side of her forehead.On 12/16/25 at 12:57 PM, V37, CNA, confirmed R9 was a very high fall risk and leaned forward in her wheelchair frequently. V37 stated that R9 often attempted to stand on her own. V37 stated that on 9/24/25, she began transporting R9 to the dining room while R9 was anxious and leaning forward in her wheelchair. As V37 began to push the wheelchair, R9 leaned forward again, placed her foot down in an attempt to stand, and fell forward out of the wheelchair.On 12/16/25 at 2:35 PM, V2, Director of Nursing, confirmed that neither staff member should have pushed R9's wheelchair forward if R9 was leaning forward or attempting to stand, which resulted in R9 falling and sustaining a hematoma to her forehead. V2 confirmed that R9 was known to have a forward-leaning posture and was a very high fall risk, frequently leaning forward in her wheelchair and attempting to stand independently. V2 confirmed that staff should ensure R9's safety during transport. V2 also confirmed that the facility did not complete fall investigations for two of R9's falls occurring on 9/11/25 and 9/20/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145546	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Zion Health & Rehab Center	1225 Woodland Drive Mount Zion, IL 62549

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145546	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Zion Health & Rehab Center	1225 Woodland Drive Mount Zion, IL 62549

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to transcribe a physician ordered medication (Coumadin) to prevent blood clot formation, for a resident post-surgical procedure, and an underlying high-risk diagnoses for blood clot formation. This failure resulted in a significant medication error. This failure affected one of 20 residents (R4) reviewed for medications on the sample list of 31. Findings include:R4's Current Diagnoses List documents the following diagnoses, which significantly increase the likelihood of blood clot development: Unspecified Encounter of Shaft of Left Femur, Subsequent Encounter for Closed Fracture with Routine Healing; Pain Due to Internal Orthopedic Prosthetic Devices, Implants, and Grafts, Subsequent Encounter; Atrial Fibrillation; Cardiomyopathy, Unspecified; Nonrheumatic Mitral Valve Disorder; Occlusion and Stenosis of Carotid Artery, Unspecified; and Atherosclerotic Heart Disease of Native Coronary Artery Without Angina. R4's hospital discharge records document that R4 was discharged from the hospital to the facility on [DATE] following Left Femur Fracture ORIF (Open Reduction and Internal Fixation), a surgical procedure required to repair a severe fracture using plates, screws, rods, and pins. ORIF of the left femur requires anticoagulation (blood thinner) therapy to prevent deep vein thrombosis (blood clots that can form in deep veins and travel to the lungs, causing a life-threatening pulmonary embolism).The same hospital discharge record documents that R4's medications were to be continued at the skilled nursing facility. R4's medication orders included Coumadin (anticoagulant/blood thinner) as follows: Coumadin 1 mg (one tablet) by mouth four times weekly on Tuesday, Thursday, Saturday, and Sunday, and Coumadin 2 mg (two tablets) by mouth on Monday, Wednesday, and Friday.The hospital discharge record further documents: Last time this medication (Coumadin) was given: November 10, 2025, at 4:47 p.m. and Take your blood thinner exactly as ordered. Do not skip doses or stop taking this drug without talking to your doctor.R4's Health Status Note on admission, dated 11/11/25 at 12:28 p.m., documents: Hospital discharge summary received and faxed to pharmacy for review.The facility pharmacy packing slip documents that R4's Coumadin 1 mg tablets (26-count) were delivered to the facility on [DATE] at 2:22 a.m. and were available for administration.R4's pharmacy requisition sheet dated 11/11/25 includes a pharmacy label documenting: Coumadin 1 mg by mouth four times weekly on Tuesday, Thursday, Saturday, and Sunday, and Coumadin 2 mg by mouth on Monday, Wednesday, and Friday.R4's Physician Order Sheet (POS) dated 11/01/25-11/30/25 does not document the initial Coumadin order upon admission on [DATE]. As a result, the electronic Medication Administration Record (MAR) did not populate the Coumadin order for administration by facility nursing staff.R4's Minimum Data Set (MDS), dated [DATE], does not document that R4 was receiving anticoagulant medication.The facility's Quality Assurance (QA) Report, dated 11/25/25 and signed by V2, Director of Nursing, documents the following:Type: Medication IncidentIncident Location: Upon admission [DATE])Prior Caregiver: V19, Licensed Practical Nurse (LPN)Witness: V29, Licensed Practical NursePhysician Notified: V4, Medical Director, 11/25/25 at 11:00 a.m.Resident Representative Notified: V42, family member/POA, 11/25/25 at 11:00 a.m.Staff Responsible for Error: V19, LPNType of Error: Missed dosesMedication: CoumadinDose Ordered: 1 mg / 2 mgRoute: PO (by mouth)Problem Statement: Second nurse did not check R4's admission orders.Why: Multiple nurses did not check or follow up on medications and discharge orders.Investigative Statement:V19, LPN, stated she thought she entered the order into the electronic medical record but later recalled the Coumadin order was confusing and that she forgot to follow up to clarify it. V19 acknowledged the Coumadin order was not entered upon admission on [DATE], resulting in 14 missed days of therapy before the error was identified on 11/25/25.The QA report also documents an additional transcription error involving the Coumadin dose and frequency, which could have resulted in further medication errors had V4, Medical Director, not discontinued the order on 11/25/25. The report incorrectly listed the higher dose on opposite days from the hospital discharge and pharmacy instructions. No Coumadin was administered from 11/11/25 through 11/24/25.R4's physician visit note, signed by V4, Medical Director, documents that R4 was seen in person on 11/25/25. V4 initiated aggressive bridged anticoagulation therapy, including injectable anticoagulant and increased oral Coumadin dosing. New orders included Lovenox 40 mg subcutaneously twice daily and Coumadin 5 mg by mouth, along with daily PT/INR laboratory monitoring to assess therapeutic anticoagulation levels.On 12/10/25 at 3:20 p.m., V19, LPN, stated she completed R4's admission on [DATE] and missed the Coumadin order due to confusion regarding the dosing schedule. V19 acknowledged several doses were missed. She stated V4 initiated Lovenox and Coumadin when the error