STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145598	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seminary Manor	2345 North Seminary Street Galesburg, IL 61401

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 - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to prevent employee to resident mental abuse for one (R1) resident out of seven reviewed for abuse. This failure caused R1 to feel blindsided, dumbfounded, and embarrassed. Findings include:The facility policy, Abuse Prohibition and Reporting (elder Justice Act), revised 11/28/19, documents not in its entirety, To protect residents from any kind of abuse such as verbal, sexual, mental, physical, including corporal punishment, involuntary seclusion, neglect, misappropriation of property, exploitation and any physical or chemical restraint not required to treat the resident's symptoms.Shift coordinators and shift nurses, will be instructed to be aware of inappropriate staff behavior and take the necessary procedure for correction of these behaviors. They would include, but not limit to derogatory language, rough handling, ignoring resident requests, and not observing appropriate safety measures that would endanger resident.Facility employee or agent who becomes aware of alleged abuse or neglect of a resident should immediately report the matter to the facility Administrator or designee. If allegation involves the Administrator then the facility employee or agent should immediately report the matter to the facility DON (Director of Nursing).The administration shall notify the resident's representative of the alleged abuse.If the incident involves alleged abuse and evidence indicates that an employee is the perpetrator of the abuse, then the Administrator shall immediately suspend the employee suspected to be involved in the alleged abuse without pay pending investigation of the incident.Interviews with all involved parties or potential witnesses will be completed. If possible, at least two interviewers shall be present for each witness interview. At least one interviewer shall take notes. Signed statements from those persons who saw or heard information pertinent to the incident shall be obtained. Statements shall be taken from the suspect, the person making the accusations, the resident abused or neglected (if cognitive level permits), other staff or residents who may have witnessed the incident, and any other person who may have information related to the incident.The following will be documented in the resident's medical record: a. The nature and extent of any injuries sustained or the condition resulting from the alleged incident. B. Whether the resident was sent to the hospital. C. Whether the resident's physician was called. R1's resident face Sheet documents that R1 admitted to the facility on [DATE] and R1's diagnoses on admission include but are not limited to Acute respiratory Failure with Hypoxia, Peripheral Vascular Disease, General Anxiety Disorder and Benign Prostatic Hyperplasia. R1's current plan of care shows no documentation regarding psychosocial well-being or interventions. On 4/24/26 at 3:00pm, R1 stated that on the morning of April 15th around 5:30am he had placed his call light on because he had to use the bathroom. A CNA (Certified Nursing Assistant) came in and asked him what he needed and he told her he needed to use the bathroom so the CNA grabbed the bedside urinal and threw it at his groin, then grabbed his penis and pushed it down toward the urinal but it didn't feel right but the CNA would not listen and just yelled, it's in, go! R1 went on to tell the CNA that it (penis) was not in the urinal and the CNA yelled again, It's in, use it! So R1 proceeded to urinate at which time R1 felt urine go all over him and the bed. R1 stated that the CNA was not happy about the mess and proceeded to forcefully close the curtain between his bed and his (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 - Actual harm Residents Affected - Few	roommates and forcefully sat R1 up on the side of the bed at which time a second CNA, not sure of her name, came in to help. The second CNA saw how angry the first CNA was about the mess and told the first CNA that she would clean it up and so the first CNA left the room. R1 stated that the CNA who was rough with him was an older lady, late 50's, and heavy set but not sure of her name. R1 stated the whole thing blindsided me; I was dumbfounded but not afraid. I was concerned and embarrassed by the whole mess. R1 also stated, No one from this facility has come to talk to me about what occurred, they have talked to my son and (R2) but not me. On 4/28/26 at 11:00am, V3 (Assistant Director of Nursing) stated that she did not speak with R1 or follow-up with him after the incident was reported to see how he was doing. On 4/28/26 at 11:15am, V4 (Social Service Director) stated that she has not spoken with R1 regarding the allegation and she has not followed up with R1 at all to check on his well-being. On 4/28/26 at 11:20am, V5 (Social Service/admission Director) confirmed that she had not personally been able to speak with R1 regarding the incident, so she does not know how he feels or what his account of the story is but V16 (Manager of assisted living) had come over and attempted to speak with R1. R1 had told V16 that he was advised not to talk. V5 also stated, I'm not sure if anyone else in our facility was able to talk with him (R1). On 4/28/26 at 11:35am, V6 (Licensed Practical Nurse), when asked about checking on R1's psychosocial well-being, stated, When I work, I talk to him and all of my residents to see how they are doing but I did not talk to R1 about anything specific related to the incident. On 4/28/26 at 2:15pm, V2 (Director of Nursing) verified that R1's Care Plan had not been revised to address R1's psychosocial well-being after the incident. On 4/28/26 at 3:45pm, V1 verified that there is no documentation in R1's medical record or investigation to prove attempts were made by the facility to speak with R1. When asked if there was any follow up to check on R1's psychosocial well-being after the allegation V1 stated, I did not see any reason to, he was showing no signs of distress. When asked if R1 not wanting to speak with facility staff could be seen as distress, V1 stated, In my mind he did not want to talk with us because the family is talking about litigation, it had nothing to do about his psychosocial well-being. The facility's investigation file documents V20 CNA was terminated at approximately 8:45 AM on the morning of 4/16 for poor quality of care, being discourteous and failure to perform job duties.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report an allegation of abuse to the Abuse Coordinator for one (R1) of seven residents in a sample of seven reviewed for abuse. Findings include:The facility policy, Abuse Prohibition and Reporting (elder Justice Act), revised 11/28/19, documents not in its entirety, To protect residents from any kind of abuse such as verbal, sexual, mental, physical, including corporal punishment, involuntary seclusion, neglect, misappropriation of property, exploitation and any physical or chemical restraint not required to treat the resident's symptoms.Shift coordinators and shift nurses, will be instructed to be aware of inappropriate staff behavior and take the necessary procedure for correction of these behaviors. They would include, but not limit to derogatory language, rough handling, ignoring resident requests, and not observing appropriate safety measures that would endanger resident.Facility employee or agent who becomes aware of alleged abuse or neglect of a resident should immediately report the matter to the facility Administrator or designee. If allegation involves the Administrator then the facility employee or agent should immediately report the matter to the facility DON (Director of Nursing).The administration shall notify the resident's representative of the alleged abuse.If the incident involves alleged abuse and evidence indicates that an employee is the perpetrator of the abuse, then the Administrator shall immediately suspend the employee suspected to be involved in the alleged abuse without pay pending investigation of the incident.Interviews with all involved parties or potential witnesses will be completed. If possible, at least two interviewers shall be present for each witness interview. At least one interviewer shall take notes. Signed statements from those persons who saw or heard information pertinent to the incident shall be obtained. Statements shall be taken from the suspect, the person making the accusations, the resident abused or neglected (if cognitive level permits), other staff or residents who may have witnessed the incident, and any other person who may have information related to the incident.The following will be documented in the resident's medical record: a. The nature and extent of any injuries sustained or the condition resulting from the alleged incident. B. Whether the resident was sent to the hospital. C. Whether the resident's physician was called. R1's resident face Sheet documents that R1 admitted to the facility on [DATE] and R1's diagnoses on admission include but are not limited to Acute respiratory Failure with Hypoxia, Peripheral Vascular Disease, General Anxiety Disorder and Benign Prostatic Hyperplasia. On 4/24/26 at 2:00pm, V15 (R1's son) stated he told V1 (Administrator) that he was not notified by the facility of the abuse allegation and had to find out about the incident from his dad, R1, and roommate R2 when he arrived at the facility on 4/15/26. V15 stated that V1 told him she had just heard about this situation and to give the facility time to investigate the situation. V15 also stated that the following day when R1 and R2 were being interviewed by local police, V1 came to the room and R2 pointed at V1 and told the police that he had reported to her the morning of the incident. On 4/24/26 at 3:00pm, R1 stated, No one from this facility has come to talk to me about what occurred, they have talked to my son and (R2) but not me. On 4/28/26 at 9:50am, R2 stated around 6am on 4/15/26, he told the CNA (Certified Nursing Assistant), unknown to R2 but verified later as V8/CNA, that he wanted to report an abuse complaint on a third shift CNA so V8 got V6 (Licensed Practical Nurse) who came to R1 and R2's room and told R1 and R2 that she would need to get someone else for them to talk to. On 4/28/26 at 11:53am, V8 (Certified Nursing Assistant/CNA) stated that approximately 9:00am on 4/15/26, R2 approached her asking who worked third shift last night and he appeared upset. V8 told R2 she was not sure because she did not see them that morning. R2 went on to tell her he thought his roommate, R1, had been abused. R2 told V8 that there were two girls one of them was nice the other one was not, ripped curtain closed. R2 stated that his roommate, R1, told him what happened, third shift CNA was very rough with him and something with a urinal. V8 stated that she went to the nurse, V6 (Licensed Practical Nurse), and told her that R2 stated he thought his roommate was abused by third shift and (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked her to go to the room with her. V8 stated that she and V6 went down to the room and when they got there, V6 asked R1 to hold on she was going to go get Social Service, so he did not have to repeat himself. When V8 was asked who the Abuse Coordinator is and who do you report abuse to V8 stated, I don't know who the Abuse Coordinator is but would report to the nurse and maybe the Administrator about it. When asked if she reported the allegation of abuse to the Administrator, she stated she did not. On 4/28/26 at 11:35am, V6 (Licensed Practical Nurse) stated that V8 (Certified Nursing Assistant) came to her around 10:00am, may be 11am give or take on 4/15/26 and reported that R1 had a complaint about third shift but did not elaborate. V6 stated she went down to R1's room and asked him what she could help him with and R1 stated he had a complaint about a third shift CNA (Certified Nursing Assistant). V6 told him she would go get Social Services, so he did not have to repeat himself. V6 stated that she called V5 (Social Service/admission Director) and told her R1 had a complaint and was told she would come and talk with R1. V6 also stated that she became aware that it was an abuse allegation when she took R1's son, V15, down to talk with Social Services and V15 stated to them, This is elder Abuse. On 4/28/26 at 11:20am V5 (Social Service/admission Director) who stated that she was told by V6 (Licensed Practical Nurse) around 11:00am on 4/15/26 that R1 had a complaint but did not state what the complaint was so V5 went down to R1's room to speak with him but R1 was sleeping and his roommate R2 had a visitor. V5 stated she attempted again but R1 was at lunch the second time. V5 stated before she could attempt to go speak with R1 again, V6 brought R1's son, V15, to her office around 3:45pm. V5 stated that she and V4 were in the office and V15 came in stating, This is Elder Abuse. This was the first time I heard anything about abuse. On 4/28/26 at 2:15pm, V2 stated that it is the policy of the facility that if staff hear the words abuse or suspect abuse they are to go directly to the Administrator who is the Abuse Coordinator to report it and if Administrator is not available then they would come to me (Director of Nursing) and if I am not available they are to go to Human Resources. They are to keep calling or looking until one of us is available. On 4/28/26 at 3:45pm, V1 (Administrator) who stated she became aware of the allegation between 3-4pm on April 15th. V1 stated, it is the expectation of staff to report any allegation of abuse to the Administrator, Me in this instance, immediately.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to thoroughly investigate an allegation of abuse for one (R1) of seven residents in a sample of seven reviewed for abuse. Findings include:The facility policy, Abuse Prohibition and Reporting (elder Justice Act), revised 11/28/19, documents not in its entirety, To protect residents from any kind of abuse such as verbal, sexual, mental, physical, including corporal punishment, involuntary seclusion, neglect, misappropriation of property, exploitation and any physical or chemical restraint not required to treat the resident's symptoms.Shift coordinators and shift nurses, will be instructed to be aware of inappropriate staff behavior and take the necessary procedure for correction of these behaviors. They would include, but not limit to derogatory language, rough handling, ignoring resident requests, and not observing appropriate safety measures that would endanger resident.Facility employee or agent who becomes aware of alleged abuse or neglect of a resident should immediately report the matter to the facility Administrator or designee. If allegation involves the Administrator then the facility employee or agent should immediately report the matter to the facility DON (Director of Nursing).The administration shall notify the resident's representative of the alleged abuse.If the incident involves alleged abuse and evidence indicates that an employee is the perpetrator of the abuse, then the Administrator shall immediately suspend the employee suspected to be involved in the alleged abuse without pay pending investigation of the incident.Interviews with all involved parties or potential witnesses will be completed. If possible, at least two interviewers shall be present for each witness interview. At least one interviewer shall take notes. Signed statements from those persons who saw or heard information pertinent to the incident shall be obtained. Statements shall be taken from the suspect, the person making the accusations, the resident abused or neglected (if cognitive level permits), other staff or residents who may have witnessed the incident, and any other person who may have information related to the incident.The following will be documented in the resident's medical record: a. The nature and extent of any injuries sustained or the condition resulting from the alleged incident. B. Whether the resident was sent to the hospital. C. Whether the resident's physician was called. R1's resident face Sheet documents that R1 admitted to the facility on [DATE] and R1's diagnoses on admission include but are not limited to Acute respiratory Failure with Hypoxia, Peripheral Vascular Disease, General Anxiety Disorder and Benign Prostatic Hyperplasia. On 4/24/26 at 3:00pm, R1 stated, No one from this facility has come to talk to me about what occurred, they have talked to my son and (R2) but not me. R1's electronic medical record or the facility reported incident investigation dated 4/15/26 has no documentation that the facility spoke with R1 regarding the allegation of abuse reported on 4/15/26. On 4/28/26 at 2:15pm, V2 (Director of Nursing) verified that there is no documentation in R1's medical record or the investigation that the facility attempted to interview R1 regarding the allegation. On 4/28/26 at 3:45pm, V1 verified that there is no documentation in R1's medical record or investigation to prove attempts were made by the facility to speak with R1.